Save the Children/Cameroon

Child Survival 9

Midterm Evaluation

Agency for International Development
Cooperative Agreement # FAO-0500-A-00-3026-00

October 1993 - October 1996

Save the Children
54 **Wilton** Road
Westport, CT 06880
(203) 221-4000

October 1995

Acknowledgements

The mid-term evaluation of Save The Children's Child Survival Project was successfully accomplished thanks to the tremendous efforts and the high quality of professionalism of the personnel and collaborators of the Ministry of Public Health and Save The Children-Cameroon. On behalf of all of the core evaluation team members, I extend our sincere gratitude. I also would like to commend all of the members of the Core Evaluation Team for their tireless dedication to maintaining standards of excellence throughout the entire process and congratulate them on a job well done.

Lydia Clemmons
Mid-Term Evaluation Team Leader

TABLE OF CONTENTS -

Save the Children/Cameroon
Child Survival 9 Midterm Evaluation

EXECUTIVE SUMMARY

1. Overview of Save The Children's Child Survival Project Strategy

Save The Children/Cameroon began implementing the CS9 project in October 1993. This collaborative effort with the Ministry of Public Health and the local communities aims at protecting children's health and lives through the establishment of co-managed, co-financed health centers in two of the six Administrative Divisions of the Far North Province, namely Mayo Danay and Mayo Kani. With a combined population of 690,473 inhabitants, the two divisions include 159,659 children under five and 160,657 women of child bearing age.

The main causes of child death in the project area as reported by the Provincial Health Delegation of the Ministry of Public Health are malaria, neonatal tetanus, acute respiratory infections, diarrhea1 diseases, malnutrition, and epidemics of meningitis and cholera.

The goal of the project is to reduce infant and child mortality rates through increasing the capabilities of the health centers to provide and support child survival activities, and the village health committees to promote access and use of the services. Impacts identified in the project design include: increased public awareness of the importance of immunization, improved sanitation in communities and increased participation of mothers and women of child bearing age in sustainable and viable maternal and child health programs. Key interventions according to the project strategy include: immunization against communicable childhood diseases, control of diarrhea1 diseases and nutrition/vitamin A education. The strategy calls for a great deal of collaboration with government health, community development, and women's empowerment agencies, as well as active, informed community participation for the successful implementation of the majority of these interventions.

2. Goal and Objectives of the Mid-Term Evaluation

The goal of the mid-term evaluation was to evaluate the Cameroon Child Survival IX project in a way that assesses its capacity to reach the stated objectives through the planned strategies and make necessary recommendations for midterm corrections.

The mid-term evaluation was from start to finish a collaborative effort between Save The Children, the Ministry of Public Health and their partners in other government services. This collaboration was achieved through the selection of a multi-disciplinary evaluation team whose members came from a number of services (specify which ones).

The mid-term evaluation took place over a three-week period from September 7 to September 27, 1995 and consisted of six principal phases: 1) planning; 2) research tool design; 3) data collection; 4) data analysis; 5) the formulation of findings, conclusions and recommendations; and 6) writing the final report. The majority of the evaluation process took place in Maroua,

regional capitol of the Far North Region of Cameroon. Data collection was carried out in villages in the Mayo Kani and Mayo Danay departments.

3. Evaluation Areas and Research Methods

During planning meetings in Yaounde and Maroua, evaluation team members reviewed USAID's Mid-Term Evaluation Guidelines, which were used as terms of reference for the mid-term evaluation. Save The Children and The Ministry of Public Health representatives at the national level agreed with the all of the evaluation areas highlighted in the USAID Guidelines and emphasized their particular interest in the areas of community participation and cost-recovery. Both parties requested that the evaluators put a special accent on these areas.

4. General Findings

The tables following this section show the results of the findings at midterm as they compare to the project objectives and outputs.

A. Immunization

Vaccination coverage rates have surpassed the project objective for complete immunization of children between 0 and 11 months yet remain well below the objective set by the Ministry of Public Health (MOH). The current immunization coverage rate for women of reproductive age is below the objective set by the project as well as by the MOH. Prior to the start-up of the project, mothers understood the importance of immunizing their children and greatly appreciated the positive impact vaccinations have had on health in their communities. This broad level understanding has continued. Although the project has made important contributions to national immunization program activities, particularly in training and in education, these inputs have not yet helped mothers to acquire accurate knowledge about immunization schedules. Mothers also have some difficulties accessing vaccination sessions, and have concerns about the quality of services.

B. Diarrhea1 Disease Control

Less than a third of the children surveyed during the mid-term evaluation had diarrea. Training provided by the project has enabled members of the health committees to accurately explain the preparation of the sugar salt soluation and how to use the oral rehydration packages. Nevertheless, the project has not had a significant impact in improving knowledge, attitudes and practices in the communities related to the control of diarrhea1 diseases. Control of diarrhea1 diseases in the project area begins with the onset of the illness rather than by prevention. The promotion of personal hygiene and environmental sanitation, clean drinking water sources, latrine construction and community clean-up days are not sufficiently addressed by the project.

C. Nutrition and Growth Monitoring

Since the baseline survey, there have been some improvements in the mothers' practices in feeding their children as well as an increase in the percentage of children with a growth monitoring chart. Nevertheless, there are not yet tangible changes in the level of mothers' knowledge about nutrition nor improvements in their ability to interpret a growth monitoring chart.

D. Vitamin A

While there is evidence that lessons on vitamin A deficiency can be well-conducted at the level of Health Centers, this education has not had an impact on mothers' knowledge. The project has trained some health committee members and women's groups on the subject of Vitamin A, yet these groups have not demonstrated a tangible impact in passing on the information they have received to their communities.

E. Community Participation

Health and Management Committees

Members of health committees are well aware of the health problems in their communities, particularly those related to child survival such as malaria, measles, diarrhea, whooping cough, infant mortality and malnutrition. Health and management committees understand their roles and most are involved to varying degrees in informing and mobilizing their communities around child survival activities. Although some health committee members brought up problems they have with credibility, most expressed the belief that their communities understand and appreciate their role. Lack of incentives has and will continue to be an important sustainability issue for health and management committee. In some cases, the committees have ceased to meet because of lack of incentives. Communities believe that they should take responsability in finding ways to provide incentives for members of health and management committees. Neither the management committee members nor the health center nurses fully understand the role of the health center management committee. Dialogue and decision-making are typically limited to counting the revenues generated by the health center and preparing the next order for medicines and supplies from the central pharmacy. In monthly meetings that generally last less than an hour, the members rarely discuss how to improve the quality of services provided in the health centers.

Women's Groups

Although nearly 40 women's groups in the two departments have received some training and have demonstrated their interest in promoting child survival activities, these groups have not been integrated into the health centers' community education and outreach programs.

Gender Issues

The vast majority (more than 95%) of health and management committee members are male. Organized women's groups, who truly represent the project's primary target groups of the children (mothers and children), have no contact with the health and management committees and do not benefit from the same training and leadership opportunities regularly provided to the mostly-male health committees. Since the start-up of the project, these men's and women's committees have evolved in separate and unequal systems, the former supported by the Ministry of Public Health and the latter supported by the Ministries of Agriculture and Community Development and of Women's and Social Affairs.

PROJECT OBJECTIVES	PROJECT OUTPUTS BY SEPTEMBER 1996	FINDINGS AT MIDTERM	SOURCE	COMMENTS
Immunizations				
1. 48% of children 0-11 mos. will be completely immunized with BCG, Polio, DPT and measles.	13,593 children under one will be completely immunized	7,693 (57.5%) of children 0-11 mos. completely immunized.	9/93 TO 7/95 Save The Children activity reports	Denominator used = 13,379 children 0-11 mos. Project objective does not conform with MOH coverage rate objective of 80%.
2. 65% of Women of childbearing age will have received at least two doses of tetanus toxoid vaccine (TT).	36,855 women of child bearing age willhave received at least two doses of TT.	14,873 (19.9%) of women of child bearing age received VAT2.	" "	The project increased this objective from 48% to 65% in December 1 994. The project object ive does not conform with MOH coverage rate objective of 80% for pregnant women. Denominator used = 76,929 women of chi ld bearing age.
3. 55% of women of child bearing age will have knowledge of the benefits of immunization.	21,230 women of reproductive age (WRA) will have knowledge of the benefits of immunization.	94.9% of mothers know that vaccines protect children against illness; 80.2% know that vaccinating a pregnant woman protects both woman and unborn child; 63.3% know that a WRA should receive at least two immunization shots. 22,777 (29%) WRA received education on the		Same knowledge levels as detected in 1994 baseline survey. Mothers still do not know immunization schedule. Between 1 3.3% and 37.8% of mothers surveyed knew the ages at which children should begin the vaccination series for the six major communicable

		importance of immunization.		childhood diseases.
PROJECT OBJECTIVES	**PROJECT OUTPUTS TO SEPTEMBER 1996**	**FINDINGS AT MIDTERM**	**SOURCE**	**COMMENTS**
	44 health centers and members of 22 COSA/COGE will have received training on the importance of immunization.	44 health center personnel, 12 COSA/COGE and 40 organized women's groups have received training.	Project monthly reports (May and June '95 monthly activity reports) were not available.	
Diarrhea				
1. At least 50% of mothers whose children had diarrhea would have reported the use of ORT.	12,334 mothers will know and demonstrate correct preparation and use of ORS, including the provisions of liquids and foods to their children during diarrhea episodes. One in every three children with diarrhea will be given ORT.	46.9% of mothers who said they give their children SSS or packaged ORT, but less than half (45.9%) of these women were able to correctly explain how to prepare these fluids. 81.8% of mothers who breast feed their children do not increase frequency of breast feeding when children have diarrhea; 95% do not increase frequency of meals. Mothers do not recognize dehydration danger signs: only 11.2% of mothers recognize sunken fontanel; 27.6% recognize dry mouth; 40.8% recognize sunken eyes; 10.2% recognize skin inelasticity.	Midterm survey and Save The Children activity reports.	The project increased the indicator from 30% to 50%.

PROJECT OBJECTIVES	PROJECT OUTPUTS 8V SEPTEMBER 1996	FINDINGS AT MIDTERM	SOURCE	COMMENTS
Diarrhea (continued)				
2. 60% of all mothers in the project area will have ɘɾ least ɵnɐ family member wbo can explain ɘnd demonstrate the correct preparation and use 0ε ORS, including the provision oɾ liquids ɘnd foods.	24,668 mothers will know the benefits 0ε using ORS in the management 0ε diarrheal episodes. 44 health center staff and members ɵε 22 COSA/COGE, ZZ women groups trained in the preparation ɘnd usɐ 0ε ORT. 22 ORT rehablitation units (onɐ in each health center) will bɐ operational. 22 health centers will have uninterrupted supplies ɵε ORS packets.	8,104 women received educaton on the benefits 0ε the use of ORT. 44 health center staff, 10 COSA/COGE and 36 women's groups have received training. 4 ouɾ 0ε6 health centers visited bɘd operational units. All six health centers visited bɘd ORT packets in stock. 9,786 packets of ORT have bɐɐn sold in the project area from 9/93 - 7/95.	Project activity reports. " Observations by evaluation team. Observations by evaluation team. Project documents.	
Nutrition				
1. 48% of children 0-36 mos. will bɐ weighed at least once every three months.	ZZ,036 children Will have bɐɐn weighed at least once every 3 months.	7,406 (24.6%) children were weighed ɜɾ least once every 3 months. 38.8% of children ɵ ɾo 36	Save The Children activity report. M idterm survey.	

		months currents nave a growth monitoring card.		
PROJECT OBJECTIVES	**PROJECT OUPUTS BY SEPTEMBER** *1996*	**RESULTS AT MIDTERM**	**SOURCE**	**COMMENTS**
Nutrition (continued)				
2, 55% of mothers will adopt appropriate feeding, weaning and food supplementation practices.	22,612 mothers will have received education on exclusive breastfeeding, appropriate weaning practices and balanced diet. I 0,972 mothers of malnourished children will have attended nutrition education and demonstration sessions. At least 22 women groups and 66 traditional birth attendents will have received training on breastfeeding, weaning and	9,47 1 mothers received education. 40% of mothers with children 0-6 months, 72.2% of mothers with children I 0- I 5 months and 7 S.6% of mothers with children 16-36 months fed their hildren green vegetables the day before the survey. The vast majority 0ε mothers (97.2%) continue co give water co their children co drink prior co the age 0ε6 months. Only 20.5% of mothers know how co interpret ∃ growth monitoring chart. 26 women's groups and 14 COSA/COGE received training. No TBAs have received training.	Save The Children activity reports. Midterm survey Midterm survey	

	nutrition. 2,295 severely malnourished children will be treated or referred.			
PROJECT OBJECTIVES	**OUTPUTS BY SEPTEMBER 1996**	**RESULTS AT MIDTERM**	**SOURCES**	**COMMENTS**
Nutrition (continued)	22 functional nutrition rehabilitation units will have been established.	No nutrition rehabilitation units exist in the six health centers visited. Documents indicate that none exist in the project area.		
Vitamine A				
1, 55% of women of child bearing age will be educated on the importance and advantages of consuming foods rich in vitamin A.	4Z,Z3O women of child bearing age wi ll know the advantages of consuming foods rich in vitamin A.	*1,996* (2.57%) women were trained.		
Z, 3O% of mothers will add vitamin A rich foods to their chi ldrens' diet.	1 Z,3 34 women will add vitamin A rich foods to their children's diet. COSA/COGE members and 22 women's groups will have been trained on preventing vitamin A	Only ZO% of mothers of children 6-9 months, 9.5% of mothers of children 10-15 months and 9.8% of mothers of children 1 6-36 months fed their children fruits the day before the survey. 55.4% of mothers donot know which foods can help prevent night blindness. 22 women's groups and 12 COSA/COGE have received training.	M idterm survey. Midterm survey. Save The Children activity reports (6-8/95).	

	deficiency.			
Nutrition (continued)	22 health centers will have supplies of vitamin A capsules.	57.1% of mothers have heard about night blindness. Of these, only 7.9% received this information from health center personnel; only 10.7% received it from health committees, and only 1.8% received it from women's groups. No capsules are available in the centers visited. Capsules are at the provincial level central pharmacy.	Midterm survey. Observations by evaluation teams.	

I. INTRODUCTION

1. Overview of Save The Children's Child Survival Project Strategy

Save The Children/Cameroon began implementing the CS9 project in October 1993. This collaborative effort with the Ministry of Public Health and the local communities aims at protecting children's health and lives through the establishment of co-managed, co-financed health centers in two of the six Administrative Divisions of the Far North Province, namely Mayo Danay and Mayo Kani. With a combined population of 690,473 inhabitants, the two divisions include 159,659 children under five and 160,657 women of child bearing age.

The main causes of child death in the project area as reported by the Provincial Health Delegation of the Ministry of Public Health are malaria, neonatal tetanus, acute respiratory infections, diarrhea1 diseases, malnutrition, and epidemics of meningitis and cholera.

The goal of the project is to reduce infant and child mortality rates through increasing the capabilities of the health centers to provide and support child survival activities, and the village health committees to promote access and use of the services, Impacts identified in the project design include: increased public awareness of the importance of immunization, improved sanitation in communities and increased participation of mothers and women of child bearing age in sustainable and viable maternal and child health programs. Key interventions according to the project strategy include: immunization against communicable childhood diseases, control of diarrhea1 diseases and nutrition/vitamin A education. The strategy calls for a great deal of collaboration with government health, community development, and women's empowerment agencies, as well as active, informed community participation for the successful implementation of the majority of these interventions.

2. Goal and Objectives of the Midterm Evaluation

The goal of the mid-term evaluation was to evaluate the Cameroon Child Survival IX project in a way that assesses its capacity to reach the stated objectives through the planned strategies and make necessary recommendations for midterm corrections.

The following tasks were outlined in the mid-term evaluation Scope of Work:

1. Assess the degree of achievement of each objective, and its expected outputs.

2. Determine whether the inputs of each objective have been implemented in their appropriate time frame.

3. Examine the implementation strategy of each objective and highlight strong and weak points.

4. Determine adequacy and appropriateness of project administration and management.

5. Evaluate the project's Health Information System

6. Assess the degree of sustainability of project interventions.

7. Analyze the budget and determine the degree of expenditures vis-a-vis outputs and determine adequacy of funds to achieve project objectives.

8. Compare the DIP's schedule of activities to actual implementation.

9. Assess the appropriateness of the tools used by the project to implement its activities.

10. Examine training programs and their effectiveness in increasing the skills and the knowledge of project participants.

11. Assess the adequacy of human resources including technical assistance to project interventions.

12. Assess adequacy of monitoring and reporting systems and their impact on performance.

13. Make necessary recommendations.

3. Overview of the Midterm Evaluation Procedure

The midterm evaluation was from start to finish a collaborative effort between Save The Children, the Ministry of Public Health and their partners in other government services. This collaboration was achieved through the selection of a multi-disciplinary evaluation team whose members came from a number of services (specify which ones).

The midterm evaluation took place over a three-week period from September 7 to September 27, 1995 and consisted of six principal phases: 1) planning; 2) research tool design; 3) data collection; 4) data analysis; 5) the formulation of findings, conclusions and recommendations; and 6) writing the final report. The majority of the evaluation process took place in Maroua, regional capitol of the Far North Region of Cameroon. Data collection was carried out in villages in the Mayo Kani and Mayo Danay departments.

The midterm evaluation work plan, the list of members of the evaluation team, and the Evaluation Topics and Methods are Annex A.

II. PHASE I: PLANNING THE MIDTERM EVALUATION

1. Identification of Evaluation Team Members

Save The Children's (SC) country office in Cameroon and The Ministry of Public Health at the national level identified a local consultant and three officials from the MOH as members of the core team for the mid-term evaluation. Save The Children headquarters in Westport, Connecticut identified an external consultant as Team Leader. The Ministry of Public Health, the Ministry of Agriculture and Community Development, and the Ministry of Women's and Social Affairs at the provincial level identified eight people from their agencies as research assistants to conduct focus group discussions. Each of the SC division offices in Mayo Kani and Mayo Danay identified six field agents to conduct the survey.

2. Review of Evaluation Guidelines

During planning meetings in Yaounde and Maroua, evaluation team members reviewed USAID's Midterm Evaluation Guidelines, which were used as terms of reference for the mid-term evaluation. Save The Children and The Ministry of Public Health representatives at the national level agreed with the all of the evaluation areas highlighted in the USAID Guidelines and emphasized their particular interest in the areas of community participation and cost-recovery. Both parties requested that the evaluators put a special accent on these areas.

3. Selection of Research Methods

For each of sixteen evaluation areas outlined in USAID's Guidelines, the core group of the mid-term evaluation team selected a combination of qualitative and quantitative research methods to provide complementary sources of information. In all, six research methods were selected to collect data:

1. Field Survey of Mothers of Children O-3 years (SURVEY)
2. Review of key documents (DOC REVIEW)
3. Review of Health Information System (HIS)
4. Observation of health care service delivery (OBSRV)
5. Interviews (INTRVW)
6. Focus Group Discussions (FGD).

The sixteen evaluation areas and the corresponding research methods used in the mid-term evaluation are presented in the table on the following page.

EVALUATION AREAS AND CORRESPONDING DATA COLLECTION METHODS

Save The Children Child Survival Project (CS9) Midterm Evaluation

AREA	SURVEY	DOC. REVIEW	HIS	OBSRV.	INTRVW.	FGD
1. Accomplishments	X	X	X			
2. Effectiveness	X	X	X			X
3. Design and Implementation		X			X	X
4. Management and Use of Data		X	X		X	
5. Community Involvement, Women's Empowerment and Overall Social Promotion		X			X	X
6. IEC	X	X		X		X
7. Human Resources		X			X	
8. Supplies and Materials		X		X	X	
9. Quality of Services				X	X	X
10. Supervision, Monitoring, Personnel Management		X			X	
11. Regional and Headquarters Support		X			X	
12. Technical Support		X			X	
13. Counterpart Relationships		X			X	
14. PVO/NGO Networking		X			X	
15. Budget Management		X				
16. Cost-Recovery		X			X	X

4. Elaboration of Work Schedule

During initial planning meetings, the Core Evaluation Team and project staff elaborated a detailed work schedule for the three-week mid-term evaluation. The work schedule is included in Annex A of this report.

III. PHASE II: RESEARCH METHODOLOGY AND TOOL DESIGN

The core evaluation team members spent two days developing research methodology and tools for the data collection. As already noted in the first section of the report describing constraints in the data collection process, the insufficient time allowed for the mid-term evaluation put many limitations on the quality of the methodology and the tools developed. For example, due to the short amount of time reserved for field work and the overall difficulty in traveling in the rural areas during the rainy season, the sample

size for the survey of mothers with children O-3 years old was limited to 98 women. While the majority of the research tools were reviewed and improved by all of the core evaluation team members before they were finalized, others, such as the focus group discussion guides, were not. Time limitations also placed important constraints on the quality of the training of the field research teams assigned to either conduct the survey of mothers or conduct the focus group discussions.

In spite of the above constraints, the research methodologies and tools developed for the mid-term evaluation succeeded in providing a good variety of valuable qualitative and quantitative data which enabled the evaluators to make an objective assessment of strengths and weaknesses in the execution of the CS9 Child Survival Project in the Far North province of Cameroon and formulate pertinent recommendations to help the project meet its objectives.

1. List and Description of Methodologies

A. Health Information System

The evaluation team reviewed the health centers' monthly activities reports, which are the primary sources of data in the project's health information system. These reports are part of the Ministry of Public Health's existing system and are compiled manually by the head nurses of the health centers and provide data for each health area. The data collection is on preventive and curative health care services. Save The Children has also initiated a monthly activities sheet, compiled by the health center nurses and community development project assistants, which focus on information, education and communication activities for each of the four components.

B. Survey

Recruiting Interviewers: The project coordinators of the Mayo Danay and in Mayo Kani departments were responsible for hiring and training a total of twelve interviewers (six in each department) were hired and trained to conduct the mid-term evaluation survey of mothers. The criteria used to select interviewers from among over one-hundred applicants included good speaking, reading and writing skills in the French language and good speaking skills in the local languages (Foufoulde and Toupouri). About half of the interviewers had had previous experience in conducting surveys.

Training Interviewers: Due to limited time and logistical constraints, the two groups of interviewers were trained simultaneously by the project coordinators in separate sites (Doukoula and Kaele). The training, held September 13-14, consisted of one-half day covering basic concepts of surveying techniques and one day pretesting and modifying the survey questionnaire.

The following subjects were covered during the training:

- Overview of the goals, objectives and strategies of the CS9 project;
- Overview of the goals and objectives of the mid-term evaluation;
- Proper conduct of an interviewer;
- Correct preparation of SSS and packaged ORS;
- Vaccination schedule for children;
- How to Interpret a Growth Monitoring Chart;
- How to ask questions and to keep interviewees interested in the survey;
- Review of the survey questionnaire;
- Translation of the questionnaire from French into the local languages (Foufoulde and Toupouri);
- Simulation/Role plays of the interviews.

Pretest: On September 14, the survey teams pretested the questionnaire in the two departments. Each interviewer practiced using the questionnaire with three women in neighborhoods in Doukoula and Kaele. Following the pretest, the interviewers returned to discuss their observations of the pretest and to modify the survey instrument. After communications and joint decision-making between Doukoula, Kaele and Maroua headquarters, the project coordinators standardized the questionnaire to incorporate the modifications suggested by both survey teams.

Description of Survey: September 15-17, the two survey teams interviewed a total of ninety-eight (98) mothers of children between the ages of 0 to 36 months in fourteen randomly selected villages in Mayo Danay and Mayo Kani. The survey assessed mothers' knowledge and practices on immunization, diarrhea1 disease control, nutrition, and vitamin A. The survey results are included in Annex B and in Section VI (Findings) in this report.

C. Document Review

Midterm evaluation team members reviewed project documents to collect quantitative and descriptive information. Among the documents reviewed were the following:

- The detailed implementation plan (DIP);
- 1994 baseline survey report;
- 1994 annual report;
- monthly and quarterly activities reports from the health centers, project coordinators, project assistants;
- supervision reports;
- project staff job descriptions;
- minutes from health and management committee meetings.

D. Individual Interviews

A total of twenty-eight (28) interviews were conducted with health personnel at the provincial and district levels. Health center head nurses were interviewed in accordance with the health areas randomly selected for the mid-term evaluation research. All other health personnel were interviewed based on recommendations from Save The Children-Cameroon project staff who identified persons key positions in decision-making concerning project activities.

Interviews covered the following topics:

- Knowledge of the CS-9 project goals, objectives and strategies;
- Role in the implementation of project activities;
- Utilization of health information system;
- Training;
- Community participation;
- Information, education and communication (IEC);
- Equipment, supplies and logistical support;
- Human resources;
- Cost recovery;
- Quality of care.

A list of the persons interviewed is attached to this report in Annex C.

E. Observation

Observations of the qualitative aspects of the project's service delivery, including education, prevention and curative care, were carried out in six health centers. Evaluation team members used two observation checklist to assess project performance based on the following criteria:

To assess quality of care:

Number of personnel;
Attitude and Behavior of personnel;
Equipment and Supplies;
Pharmaceutical drugs;
Cold chain;
Diagnosis and Treatment of Illnesses.

To assess performance of educator conducting Information, Education and Communication (IEC) sessions..

Greetings;
Introductions;

Relaxed atmosphere;
Introducing the subject;
Asking participants questions;
Correct information provided;
Use of audio-visual supports;
Responding to participants' questions;
Level of Participation;
Evaluation;
Wrap-up and thank yous;
Date of next lesson;
Appropriate use of local language and customs.

Copies of the observation checklists are attached to this report in Annex D

F. Focus Group Discussions

A total of sixteen focus group discussions were held by trained research assistants for the midterm evaluation. Nearly 130 men and women were participants in the discussions.

Focus Group Discussion (FGD) research is a qualitative method of data collection. Each FGD is held with six to twelve participants belonging to a target group. Ideally, all of the participants in each group have similar socio-economic characteristics, including age, gender, ethnicity, education, profession, etc. A homogeneous group of participants is crucial in order to provide a general portrayal of the target group's knowledge, values, attitudes, opinions and practices. Homogeneity also helps to create a relaxed group dynamic in which participants will feel at ease enough to express their views.

Description of groups: For each of the divisions, the evaluation team identified the following participant categories for the focus group discussions (FGDs):

- Two groups of male members of Health Committees or Management Committees;
- Two groups of members of organized Women's Groups;
- Two groups of married adult male beneficiaries between the ages of 30-40;
- Two groups of married adult female beneficiaries between the ages of 25-35.

Recruitment of research assistants: The provincial-level offices of the Ministry of Public Health, the Ministry of Agriculture and Community Development, and the Ministry of Women's and Social affairs, all based in Maroua, identified moderators and reporters for the focus group discussions. Ideally, four men and four women would have been selected, but constraints in the availability of human resources made it necessary to hire six women and two men instead. Criteria used for the selection of the moderators and reporters included good speaking, writing and reading skills in the French language, good speaking

skills in the local languages, and previous experience in conducting focus group discussions.

Training of research assistants: On September 13, the eight members of the FGD teams participated in a refresher course given by the Evaluation Team Leader. The refresher course was held in Save The Children's office in Maroua. One-half day was devoted to covering the basic concepts of focus group discussion methods and one day was devoted to pretesting and modifying the discussion guides.

The following subjects were covered during the refresher course:

- Overview of the CS-9 child survival project goals, objectives and strategies;
- Goals and Objectives of the mid-term evaluation;
- Advantages and limitations of qualitative research;
- The importance of values, perceptions, beliefs and attitudes;
- Personalizing the "target group";
- Description of focus group discussion methodology;
- How to establish trust and a relaxed atmosphere;
- The importance of non-verbal communication;
- The art of asking questions;
- The art of facilitating a group discussion;
- The role of the moderator and the note-taker;
- Review of the discussion guides;
- Translation of the discussion guides;
- Simulation and roles plays.

Pretest: Due to time constraints, only the female members of the FGD teams had the opportunity to practice using one of the questionnaires with an organized women's group in a nearby neighborhood. Limited time was available for discussion and improvement of the focus group discussion guides.

Discussion Guides: Two discussion guides were developed for the focus groups. One guide was used in discussions with male or female beneficiaries while the other was used in discussions with health and management committees or with organized women's groups. Both discussion guides covered the following subjects:

- General health in the community;
- Role of Health and Management Committees and/or Women's Groups;
- Immunization;
- Diarrhea1 Disease Control;
- Nutrition; and
- Quality of Care.

A copy of the discussion guides is attached to this report in Annex E.

2. List and Description of Tools

The following research tools were developed by the Core Evaluation Team and can be found in the Annexes of this report

A. Survey Questionnaire for Mothers

B. Focus Group Discussion Guide for Health Committees, Management Committees and Women's Groups

C. Focus Group Discussion Guide for Male and Female Beneficiaries

D. Observation Checklist for IEC activities

E. Observation Checklist for Quality of Health Services Delivery

F. Document Review Worksheet

G. Interview Guide for District-Level Health Personnel and Collaborators (health center nurses, other PVOs or NGOs)

H. Interview Guide for Provincial-Level Health Personnel and Collaborators (Provincial Delegates, Etc.)

I. Interview Guide for Save The Children Staff

Iv. PHASE III: DATA COLLECTION

Two separate field evaluation teams carried out data collection in the Mayo Kani and Mayo Danay departments during a four-day period. A total of fourteen villages in six health areas (seven villages and three health areas in each department) were randomly selected for field data collection.

Following their field work the two research teams regrouped in Maroua for a debriefing session on the strengths and weaknesses of the process of collecting the mid-term evaluation data in the field. The group also formulated recommendations for future evaluations entailing field work. The strengths, weaknesses and recommendations identified during the debriefing session are listed below:

A. Strengths of the Field Data Collection

The field teams identified the following positive points in the field data collection process.-

1. The planning of activities was well done and included a clear distribution of tasks for each member of the team.
2. There were good group dynamics during the preparation and the implementation of the evaluation activities.

3. The communities were informed in advance of the arrival of the evaluation teams and understand the reason for their visit.

4. The communities were generally welcoming and available.

5. The evaluation program was flexible enough to adapt to unanticipated problems in the field.

6. Lodging for the evaluation teams was prepared in advance.

7. Meals were organized for the evaluation teams in Doukoula

8. In spite of the difficulties and constraints (the rainy season, the short length of time planned for the survey, and insufficient logistical support), the activities were successfully accomplished in the pre-determined areas and in the allotted time.

9. All of the evaluation team members were willing to work hard and long hours to accomplish their tasks.

10. The six research methods selected for the mid-term evaluation were well adapted, easy to use and complementary.

11. The step-by-step approach used to prepare and implement the mid-term evaluation was a participatory adult learning process for the evaluation team members who appreciated being actively involved in the design and use of the research tools.

12. The multi-disciplinary composition of the teams enriched the entire mid-term evaluation process, from the design of the research tools through the analysis of the data

13. The materials necessary to carry out the field work were made available to the evaluation teams.

14. The presence of escorts for the teams in Mayo Danay facilitated the field research in the communities.

15. The management of time and of human resources was flexible enough to allow changes in the organization of the work that overcame unforeseen constraints in the field,

B. Weaknesses of the Field Data Collection

The field teams identified the following constraints and difficulties in the field data collection process:

1. Duration: The three-week period allotted for the mid-term evaluation created many insufficiencies in the preparation and the execution of the field data collection process, including:

i) The time allotted for the training of the research teams and the pretesting of the research tools (two days) for the Focus Group Discussions and the field survey was insufficient and do not permit the teams to adequately improve and familiarize themselves with the tools.

ii) The time allotted for conducting the research activities was insufficient to permit a larger sample of mothers for the field survey.

iii) The preparation of the research tools was hastily done.

iv) The field teams had to work late hours and on weekends at an intense rhythm, leading to exhaustion and even illness among some of the team members.

v) The time available to identify appropriate interviewers was insufficient, resulting in having two instead of four male interviewers and reporters for the focus group discussions with men.

2. Rainy Season: The rainy season is an extremely inappropriate period to conduct field research. The timing of the research during a time when the majority of the roads, particularly in Doukoula were virtually impassable by vehicles, created the following difficulties and constraints:

i) Certain preselected villages and health centers had to be dropped from the evaluation program because they were completely inaccessible.

ii) The exchange of information between the two divisions was greatly diminished due to the difficulty in assuring regular transportation between them.

iii) Supervision of the Focus Group Discussion and survey teams became very difficult, due in part to the poor road conditions.

3. Logistics: The organization and the logistics for the field work was insufficient, partially due to the lack of time, partially due to a lack of proper planning and management. This weakness in the process resulted in the following difficulties and constraints:

i) Lack of team debriefings at the end of each day;

ii) Inadequate organization for meals;

iii) The tape recorders purchased, although tested prior to the field work, proved to be of poor quality and did not record the discussions.

iv) The number of vehicles was insufficient for the timely transportation of the different teams.

4. Workload: Some research team members had too many tasks. Secretarial support during the preparation of the research tools and during the data analysis was insufficient, causing important delays in preparing the final report.

C. Recommendations for Future Project Evaluations

The field teams recommend the following points to improve the field data collection process during future evaluations.

Save The Children-Headquarters and USAID should:

1. Program at least one additional week for the entire mid-term evaluation (four instead of three weeks) in order to:

- better design the questionnaires and guides (plan at least six work days to train the research teams in the methods and to pretest and improve the tools for the focus group discussions and the field survey).

- better implement data collection in the field (plan at least five work days in the field).

- increase the sample size for the survey (at least two hundred mothers)

2. Make sure that the dry season is chosen for the evaluation period (the months of November through February are ideal because the temperature is also mild).

Save The Children-Cameroon and the Ministry of Public Health should:

1. Use the same research methodologies and the same participatory learning approach.

2. Utilize the same individuals from the Ministry of Public Health who participated as members of the mid-term core evaluation team in the final evaluation of the child survival project.

3. Make sure that the training for the research teams conducting the survey and the focus group discussions is held in the same place and by the same people.

4. Make sure that all secretarial, logistical and administrative support for the evaluation teams is well-identified ahead of time and made available when needed.

5. Schedule evaluation activities during work days and avoid scheduling weekends.

6. Make sure that there is a debriefing among the field research teams at the end of every day in order to verify data and troubleshoot.

7. Make sure that the field teams have a first-aid kit of medical drugs and supplies (including aspirin and chloroquine).

8. Assign escorts to accompany the field teams and introduce them to the communities,

9. Organize a regular supervision and follow-up of the teams conducting the surveys and the focus group discussions in order to standardize the approaches and to rapidly facilitate problem-solving.

10. Plan more appropriate logistical support in the future: vehicles, quality tape recorders, organized meals.

11. Identify and recruit a sufficient number field team members to conduct the surveys and the focus group discussions well ahead of time.

V. PHASE IV: DATA ANALYSIS

During a four-day period, evaluation team members worked in sub-groups to conduct a preliminary analysis of the data they had collected using a combination of the six research methods. Initial results were presented during plenary discussions during which certain problem areas or weaknesses in the analysis were highlighted, leading to a later, more detailed analysis by the two external consultants.

VI. FINDINGS AND RECOMMENDATIONS

Following the data analysis, preliminary findings of the mid-term evaluation were presented by the evaluators to the provincial delegate of the Ministry of Public Health in Maroua and to the Ministry of Public Health in Yaounde. Save The Children staff actively participated in the presentations at both levels.

The two consultants spent one day in Yaounde to discuss the preliminary findings and the writing of the final report.

1. Design and Relevance of the Project

The original project design integrates well into the Ministry of Public Health's policies and national reorientation strategy for primary health care. The strategy also reinforces collaboration between the Ministry of Public Health and the Ministries of Agriculture and Community Development, and Women an Social Affairs. In addition, the project's strategy places an emphasis on community participation that, if successfully implemented, would enhance sustainability. The project inputs focusing on training, follow-up and support for women's groups as well as for traditional midwives are an extremely important aspect of the design that would enable women to have active roles in decision-making over the activities and resources provided through the project.

Weaknesses in the project design include that the project objectives do not reflect a tangible benefit for zones receiving the additional human, material and financial resources brought by the project as compared to zones without the project. To the credit of project managers, certain objectives have been altered since the project design to reflect this additional investment. For example, the objective for vaccination coverage rate for women in their reproductive years was increased from 48% receiving at least two doses of tetanus toxoid vaccine to 65%. Also, the project increased the objective for percentage of mothers saying that they use oral rehydration therapy for children with diarrhea from at least 30% to at least 50%.

Nevertheless, many objectives in the project strategy, particularly those concerning immunizations, remain below those of the government health strategy. For example, while the government has the objective to completely vaccinate 80% of children 0 to 11 months

against the six communicable childhood diseases, the project only sets 48% as its objective. The immunization target of 48% was developed during the proposal phase because at that time the MOH estimates for the vaccination coverage rate of children O-l 1 months of age was 7%.

Other weaknesses in the strategy occur particularly in the diarrhea1 disease control component and the vitamin A component. In the former, the emphasis is put almost exclusively on treatment of diarrhea and dehydration and little attention is placed on prevention. In the design as well as in the messages developed for the project, construction of latrines and clean drinking water sources, the organization of community clean-up days (environmental hygiene) and personal hygiene rules are barely discussed.

Concerning vitamin A deficiency, this illness was not seen as an important issue during the conception of the project: only 0.71% of children who had participated in a study showed clinical signs of vitamin A deficiency. The project did not consequently budget for vitamin A capsules. It is unclear why a special component was designed for this vitamin A deficiency prevention, which could have been conceptualized as simply part of the nutrition component.

With the exception of Save The Children, the different key players in the project seem to have only a superficial knowledge of the project and its objectives, suggesting that the Detailed Implementation Plan (DIP) was either insufficiently distributed and discussed, or else insufficiently used as a reference by the partner agencies (the Ministries of Health, of Agriculture and Community Development, and of Women and Social Affairs).

2. Overall Accomplishments and Effectiveness in Light of Objectives and Outputs

Summary of Overall Accomplishments and Effectiveness: With the exception of the project objective for immunization coverage rates for children 0 to 11 months of age, which has been reached, the other project objectives were less than halfway attained at the time of the midterm evaluation. The establishment and training of health committees and women's groups is well underway. Nevertheless, these community groups have not yet demonstrated a tangible impact in their primary role of improving mothers' knowledge, attitudes and practices related to child survival. Turnovers of key project personnel have had deleterious effects on the project's activities and have contributed to the project being approximately eight months behind schedule in the implementation of its strategies.

A. IMMUNIZATION

Summary: Currently, 57.5% of children between the ages 0 and 11 months are completely immunized against the six major communicable childhood diseases. This vaccination coverage rate surpasses the project objective of 48% yet remains well below the coverage rate objective of 80% set by the Ministry of Public Health (MOH). Only 19.9% of women of child bearing age had received at least two doses of tetanus toxoid vaccine at the time of the midterm evaluation. This coverage rate is well below the objective of 65% set by the project as well as below the objective of 80% set by the MOH. The project has trained 44 health center nurses, 22 health and management committees

and 40 organized women's groups on the subject of immunizations. Yet these inputs in training and education have not had a beneficial impact on mothers' knowledge and attitudes about immunizations. Mothers also have some difficulties accessing vaccination sessions, and have raised concerns about the quality of some immunization services.

A 1. Immunization Coverage Rates

Strengths:

A 1.1 The project set as an objective that 48% of children between O-1 1 months of age will be completely immunized against the six major communicable childhood diseases targeted by the national immunization program. The field survey indicates that the project has surpassed this objective by completely vaccinating 57.5% of children in this age group.

A 1.2 The project has helped organize a regular schedule for immunization sessions in the health centers and in the villages developed by the personnel in collaboration with the health and management committees.

Weaknesses:

A 1.3 Although the project has surpassed its own immunization coverage rate by completely vaccinating 57.5% of children between the ages of 0 and 11 months, this rate is nevertheless well below the Ministry of Public Health's objective of completely immunizing 80% of children in this age group.

A 1.4 The project set an initial objective of vaccinating 48% of women of child bearing age with at least two doses of tetanus toxoid vaccine. In 1994, the project increased this objective to 65%. The mid-term evaluation review of the health information system indicates that only 19.9% (14,873) women of reproductive age, have received the second dose of tetanus toxoid vaccine.

A 1.5 In their objectives for controlling neonatal tetanus, the project targets all women of child bearing age while the Ministry of Health specifically targets pregnant women. Interviews conducted by the evaluation team revealed that recent attempts to bring conformity in immunization objectives has created a general confusion among personnel in both the government health services and in Save The Children-Cameroon at the provincial, departmental and health area levels. Some personnel have understood high-level government officials' clarifications on target groups to mean that ***only*** pregnant women can be vaccinated and that all other women are to be ***excluded*** from receiving tetanus toxoid vaccinations.

A 2. Equipment, Supplies and Logistical Support for Immunization

Strengths:

A 2.1 A review of project documents shows that the project has financed the transport of five motorcycles belonging to the Ministry of Public Health from Yaounde to Maroua.

A 2.2 Interviews, observations and a review of project documents show that the central pharmacy in Maroua (CAPP) assures a continuous supply of disposable needles and syringes.

A 2.3 Interviews with staff of Save The Children-Cameroon reveals that the organization has identified funds and will soon be assuring the repair of all refrigerators in the project area which are out of order.
A 2.4 Interviews with government health Personnel indicate that the central pharmacy (CAPP) is in the process of establishing a system in which it will keep a stock of refrigerator and motorcycle spare parts to facilitate timely repairs.

A 2.5 Each of the project coordinators has a vehicle which they use to assist in the transport of vaccines to the health centers.

Weaknesses:

A 2.6 Observations conducted by the evaluation teams revealed that four of the six health centers randomly selected for visits did not have a functioning cold chain because the refrigerators were out of order.

A 2.7 An official, consistent system is not in place for transporting vaccines to the health centers.

A 3. Training and Education in Immunization

Strengths:

A 3.1 According to project documents, the project has trained forty-four (44) health center nurses in the national immunization program's objectives, policies and procedures, meeting one of its stated outputs. Twelve (12) health and management committees and forty (40) women's groups have also received training about immunization.

A 3.2 The project has contributed to designing a curriculum and conducting a seminar on the importance of immunizations for community leaders, women's groups, and health and management committees.

A 3.3 Focus group discussions with health committees indicates that the members have understood their responsibilities in passing basic information on immunization to their communities:

> *"(Our job is to inform people about) the vaccination schedules, the advantages and disadvantages of vaccinations, the importance of having a new needle, the fact that vaccines do not kill and do not make human beings sterile."*

" We participate in vaccination sessions. Our role consists of maintaining order, gathering the vaccination cards, organizing the vaccination site, directing mothers and raising their awareness about coming backfor the next vaccination session. "

"When there is a vaccination session, there is someone who collates the cards, someone who vaccinates, and a consultation post. "

A 3.4 Focus group discussions held with women's groups during the mid-term evaluation also revealed that their members also volunteer to encourage mothers to get their children immunized and help organize vaccination sessions.

A 3.5 Health center personnel, along with government community development field agents *("animateurs"),* health committees and women's groups have conducted community education sessions on the importance of immunizations in the health centers and in some villages.

Weaknesses:

A 3.6 Interviews conducted by the evaluation team members revealed that vaccination coverage rates for individual villages are often not known by the health center head nurses, who sometimes generalize data collation for the entire health area. The health center head nurses do not usually discuss vaccination coverage rates at the village level during their meetings with the health committees. This practice limits the degree to which health center personnel and health committee members can monitor progress in achieving immunization objectives at the community-level.

A 4. **Community** Knowledge and Attitudes about Immunization

Strengths:

A 4.1 Women and men who participated in the focus group discussions demonstrated a good understanding of the importance of immunizations:

"Vaccinations are good for you. "

'Thanks to the vaccinations, there are no longer a lot of deaths after measles; children are less threatened. "

"(Vaccinations) protect the child.

"Certain villages who didn't follow (accept) the vaccination against measles suffer a lot from child mortality when an epidemic comes in their village. We've had a lot of these examples. "

A 4.2 The field survey confirms that mothers have good general knowledge and attitudes about vaccinations:

- When asked what vaccinations are for, nearly ninety-five percent (94.9%) of mothers surveyed replied that vaccinations protect children against illnesses.

- Nearly eight-one percent (80.2%) of mothers surveyed also knew that vaccinating a pregnant women protects both the women and the unborn child.

- Sixty-three percent (63.3%) of mothers also knew that women in their child bearing years should receive at least two immunization shots.

It should be noted, as indicated by the baseline survey results, that *these strengths in knowledge and attitudes do not reflect those* ***of*** *the current project but rather* ***represent*** *a knowledge level already acquiredprior to the project start-up.*

Weaknesses:

A 4.3 The field survey indicates that mothers do not yet know enough about immunization schedules for children. Of the mothers surveyed:

- only 37.8% correctly identified the age at which children should be vaccinated against tuberculosis;

- only 13.3% identified the age at which children should begin vaccinations against polio;

- only 19.4% correctly identified the age at which children should begin vaccinations against diphtheria;

- only 3 1.6% correctly identified the age at which children should begin vaccinations against whooping cough;

- and only 36.7% correctly identified the age at which children should begin vaccinations against measles.

A 4.4 Focus group discussions with health committee members and beneficiaries confirmed that while communities' appreciate the importance of immunizations, they do not really understand vaccination coverage rates and what being "completely immunized" means, Members of health committees and women's groups as well as beneficiaries all highly overestimated coverage rates in the villages:

"The coverage is good: twice a week in the two health centers."

"For the vaccination coverage rate, 3/4 ***of*** *the village is vaccinated because the mothers hurry to bring the children to be vaccinated."*

'All ***of*** *the villages are covered (completely vaccinated) just fine."*

"If you were to pick four children by random, three would be vaccinated since each child who is born is registered and the mother must bring the child to be vaccinated with the advice of the health center head nurse."

Because they mistakenly assume that their families and villages are already well protected (currently, 57.5% of children aged O-l 1 months are completely vaccinated in the project area), communities may underutilized immunization services.

A 5. Issues of Quality of Care and Access for Immunizations

Strengths:

A 5.1 As mentioned earlier in this section, communities greatly appreciate the immunization services provided by the Ministry of Public Health and Save the Children.

A 5.2 In the two health centers where there were functioning refrigerators, the immunization cold chain was well monitored with refrigerator temperature records and organized stocks of vaccines. Aside from drinking water observed by the evaluators in one of the two functioning refrigerators, nothing other than vaccines were stored in the refrigerators.

Weaknesses:

A 5.3 As mentioned earlier in this section, health center personnel often confuse government policy regarding the use of sterilizable needles and syringes. Although sterilization kits were available in all of the health centers visited, it was evident that they were rarely used. Health personnel often believe that they should only use single-use needles and syringes.

A 5.4 Mothers complain about problems typically associated with incorrectly administered vaccine injections and incorrect sterile technique:

"When the nurse gives the vaccination badly, the child becomes sick. It swells."

"For example, my sister's child had a big wound because of a vaccination."

'The place (where the injection was given) often swells and this can provoke a wound and even pus. This often discourages the children 's' parents."

"Certain nurses give injections badly and the child is not able to manage to walk."

A 5.5 Following a successful AIDS awareness-raising campaign in the project area, there has been some confusion not only among the communities but also among the health personnel regarding the use of sterilizable needles.

a. In some health areas, only single-use needles and syringes are used during immunization clinics, obtained from the government-run pharmacy and sold to beneficiaries at 100 francs.

b. In other health areas, while both single-use and sterilizable needles and syringes are made available to beneficiaries, a certain social stigma has been attached to mothers letting their children be immunized with re-usable needles. The stigma depicts these mothers as 1) too poor to buy single-use needles and 2) negligent about the health and welfare of their children because using sterilizable needles is believed to greatly increase the risk of getting AIDS.

c. Even where sterilizable needles are available, mothers who do not have the financial means to buy single-use needles for their children feel discouraged from attending the vaccination clinics:

"When you don't have money, they vaccinate you with a used needle. "

"They vaccinate with a used needle if you don't have the means and then you get ill."

"The disadvantage of vaccinations is that one can get contaminated by AIDS by using the same syringe. "

"The members of the health committee inform the women about the vaccination schedule. They ask them to bring one syringe per child. "

"What prevents us from going is (lack of) financial means to pay the syringes, alcohol and cotton. "

"(To improve the vaccination program), reduce the price of-.. syringes and increase the vaccination sessions. "

A 5.6 Other barriers to access to vaccination sessions for women include distance, the rainy season during which roads become impassable, and the need to work in the fields in order to grow food for the family.

A 6. Recommendations for the Immunization Component

A 6.1 Save The Children-Cameroon and the Ministry of Public Health should revise the project target group and clarify the project policy for tetanus toxoid vaccine immunizations. Project officials should notify Save The Children headquarters and USAID of these changes.

A 6.2 Specifically, the objective for the coverage rate for tetanus toxoid vaccine should be modified so that 80% *ofpregnant women will receive at least two doses of tetanus*

toxoid vaccine. The policy should be that *health personnel will continue to immunize all women of reproductive ages against tetanus as the opportunity presents itself.* The number of pregnant women immunized against tetanus will be the new indicator for coverage rates. The number of all women of reproductive ages immunized should also be recorded to reflect project impact.

A 6.3 The Ministry of Public Health and Save The Children should clarify instructions to health personnel concerning the use of sterilizable needles. These agencies should also organize a public information campaign to reduce the stigma attached to using sterilizable needles.

A 6.4 The Ministry of Public Health should organize a routine inspection during vaccination sessions in the health centers and in the villages to assess the quality of services.

A 6.5 If indicated by the results of the inspection recommended above, the Ministry of Public Health should provide on-the-job refresher courses to improve the immunization techniques of health center personnel, particularly the proper sterilization of needles and syringes.

B. DIARRHEAL DISEASE CONTROL

Summary: Training provided by the project has enabled members of the health committees to accurately explain the preparation of the sugar salt solution and how to use the oral rehydration packages. Nevertheless, the project has not had a significant impact in improving knowledge, attitudes and practices in the communities related to the control of diarrhea1 diseases. 45.9% of mothers who said they gave SSS or ORT to their children with diarrhea knew how to correctly prepare these liquids. 81.8% of mothers who breast feed their children do not increase the frequency of breast feeding when their children have diarrhea. 95% of mothers say they do not increase the frequency of feeding for their children with diarrhea. Control of diarrhea1 diseases in the project area focuses more on curative care than on prevention. The promotion of personal hygiene and environmental sanitation, clean drinking water sources, latrine construction and community clean-up days are not sufficiently addressed by the project.

Strengths:

B 1. Community Knowledge and Practices concerning Diarrhea1 Disease Control

B 1.1 Comparisons between baseline and midterm surveys indicate that fewer children have diarrhea in the project area. 32.7% of mothers who were interviewed during the midterm evaluation survey said that their children had had diarrhea in the last fifteen days.

40.6% of mothers interviewed during the baseline survey said that their children had had diarrhea in the last fifteen days.

B 1.2 Almost all mothers know at least one danger sign for a child with diarrhea and have had this knowledge prior to the start-up of the project. During the baseline survey, 92.9% of mothers knew at least one danger sign and at the midterm, virtually the same amount (9 1.8%) of mothers knew.

B 1.3 46.9% of mothers said that they give their children sugar-salt solution (SSS) or pre-measured oral rehydration salts to their children when they have diarrhea. This percentage represents a significant improvement since the time of the baseline survey and is close to the stated objective of the project of at least 50% of mothers whose children had diarrhea reporting the use of ORT.

B 1.4 There has been some improvement in mothers' breast feeding practices when their children have diarrhea. 18.2% of mothers interviewed in the midterm survey, as compared to only 9.3% interviewed in the baseline survey said they breast feed their children more than usual when they have diarrhea.

Weaknesses:

B 1.3 When one makes the comparison between the baseline survey results and those of the mid-term evaluation survey, while there has been some improvement in breast feeding practices, it is evident that the project has yet not had significant impact on the overall knowledge and practices of mothers in the treatment of diarrhea and dehydration:

i. 97.2% of mothers give their children water to drink prior to six months of age

ii. 8 1.8% of mothers who breast feed their children do not increase the frequency of breast feeding during bouts of diarrhea in their children (63.6% said that they breast feed as usual and 18.2% said that they breast feed less than usual).

iii. 95.% of mothers say that they do not increase the frequency of meals that they given to their children during bouts of diarrhea in their children (33.3% of mothers give meals as usual and 61.9% give fewer meals than usual).

iv. Most mothers still do not recognize dehydration danger signs:

Only 11.2% recognize sunken fontanel; only 27.6% recognize a dry mouth; only 40.8% recognize sunken eyes; and only 10.2% recognize skin inelasticity (as demonstrated by skin fold).

v. Although nearly half (46.9%0 of mothers interviewed say they give oral rehydration fluids to their children with diarrhea, most of these do not know how to prepare these fluids correctly. 54% of mothers interviewed who said that they

give SSS or that they use the pre-measured oral rehydration salts either admitted they do not know how to prepare these fluids or were unable to correctly explain how to do so.

B 1.4 Although the promotion of potable water and the use of latrines is a project strategy identified in the Detailed Implementation Plan (DIP) for the control of diarrhea1 diseases, the review of project documents confirmed that these activities are not covered by the project. Nevertheless, focus group discussions revealed that clean drinking water is often inaccessible in the communities and is an expressed need:

> *"There are water wells andpumps (forrages) in... certain villages, But in the remote villages, the population gets its drinking water from the swamps and in the open-air traditional wells. "*
>
> *"In the villages, drinking water is not clean. "*
>
> *"The drinking water is dirty. "*
>
> *"Wells are necessary in order to have clean drinking water. "*

B 2. Training and Education in Diarrhea1 Disease Control

Strengths:

B 2.1 Forty-four (44) health center staff have received training in diarrheal disease control. Thirty-six (36) women's groups and ten (10) health and management committees have also been trained. Eight thousand one hundred and four (8,104) women attended educational sessions on the use of the packaged oral rehydration salts.

Weaknesses:

B 2.1 Interviews and the focus group discussions held during the mid-term evaluation revealed that the health center nurses and the members of the health committees think that *all* cases of diarrhea must be automatically sent to the Health Centers. This not only reflects a confusion in the interpretation of instructions given by health service decision-makers but also defeats the purpose behind the objective of educating mothers about diarrhea, dehydration and home preparation of oral rehydration solutions.

B 2.2 Interviews and focus group discussions revealed that there is a lack of consistency in the health messages concerning the length of time recommended for exclusive breast feeding. The project personnel, health center head nurses and health committees understand the message to recommend exclusive breast feeding for 6 months while the national policy advises a 4 to 6 month period.

B 2.3 Interviews, focus group discussions, the review of project documents and observations conducted during the mid-term evaluation revealed a lack of IEC materials on diarrhea1 disease control in the Health Centers as well as in the communities.

B 2.4 Interviews and the review of project documents revealed that traditional mid-wives have not received any training and are not integrated into diarrhea] disease control activities at the community level.

B 3. Supplies, Equipment and Logistical Support for Diarrhea] Disease Control

Strengths:

B 3.1 All six of the health centers visited by the evaluation team had ORS packets in stock.

Weaknesses:

B 3.3 Few of the six health centers visited had functioning latrines, and of those that did exist, none were well-maintained.

B 4. Issues of Access and Quality of Care in Diarrhea1 Disease Control

B 4.1 According to the Detailed Implement Plan (DIP), each of the approximately 46,000 children between the ages of 0 and 36 months in the project area has diarrhea an average of 4 to 5 times each year. This would mean that there are between 184,000 to 230,000 episodes of childhood diarrhea each year. Yet project documents show that only 9,786 packets of oral rehydration salts (ORS) have been sold in the project area from 9/93 - 7/95, indicating that these packages are far from being in high demand. The midterm evaluation did not uncover whether this lack of demand is due to price or to accessibility. Although the evaluation did show that ORS packets are available in the health centers, it did not uncover whether the lack of demand is due to their price, to the distance of health centers from homes, and/or to mothers' preferring to use home-made solutions.

B 5. Recommendations for the Diarrhea1 Disease Component

Save The Children and the Ministry of Public Health should:

B 5.1 Clarify instructions to all health personnel concerning management of diarrhea

B 5.2 Integrate traditional birth attendants into the diarrhea1 disease component of the project strategy as described in the Detailed Implementation Plan (DIP).

B 5.3 Organize training and/or refresher courses for health personnel, health committees, women's groups *and traditional birth* attendants in educating mothes about home management of diarrhea for cases that do not require hospitalization. Home management

includes preparation of oral rehydration solutions, appropriate feeding practices, including breast feeding, and recognition of danger signs that would require evacuation to a health center.

B 5.4 Provide a variety of audio-visual aids for health educators (health personnel and community volunteers) to facilitate educational lessons. Audio-visual aids should include:

* audio-taped stories, songs or theater skits;
* illustrations painted on large cloth; and
* plastic bags which can be filled with water and then punctured to demonstrate the process of dehydration.

B 5.5 Organize an intensive information, education and communication (IEC) campaign in the communities to reinforce the awareness-raising activities of the health committees and women's groups. The IEC campaign should use a variety of media (such as songs, theater plays, tee-shirts, audio-taped stories or fables, traditional Cameroonian media, informational radio spots) to pass messages on:

* the prevention of dehydration during episodes of diarrhea;
* dehydration danger signs;
* how to correctly prepare the sugar and salt solution (SSS), cereal-based oral rehydration solutions, and packaged rehydration salts.
* exclusive breastfeeding.

B 5.6 Assess community needs for clean drinking water sources through information provided by health committees and women's groups in the villages covered by the project.

B 5.7 Where need for clean drinking water sources has been established, discuss each agency's role in collaborating to meet these needs through available human, material and financial resources.

B 5.8 Assure that functioning latrines are constructed and maintained in each health center.

B 5.9 Conduct a brief survey to determine the reasons for the low utilization of packaged oral rehydration salts. As appropriate in light of the survey findings, develop a policy to increase the accessibility of the packages as well as to increase corect preparation of home-made oral rehydration solution.

C. NUTRITION AND GROWTE MONITORING

Summary: Since the baseline survey, there have been some improvements in the mothers' practices in feeding their children as well as an increase in the percentage of children with a growth monitoring chart. For example, 75.6% of mothers with children between the ages of 16 and 36 months fed their children green vegetables

the day prior to the survey. Nevertheless, there are not yet tangible changes in the level of mothers' overall feeding practices nor improvements in their ability to interpret a growth monitoring chart. Only 20.5% of mothers interviewed were able to identify the "road to good health" on the chart.

C 1. **Community** Knowledge and Practices concerning Nutrition and Growth **Monitoring:**

Strengths:

C 1.1 According to the baseline survey, 46% of mothers interviewed gave green vegetables to their children. The midterm evaluation survey results indicate that there is an improvement in this practice. Overall, 54.1% of mothers said their children ate green vegetables, The percentage of mothers of children in specific age groups who said they gave their children green vegetables the day before the midterm evaluation survey is as follows:

- 40% of mothers with children between the ages of 0 and 6 months;
- 72.2% of mothers with children between the ages of 10 and 15 months; and
- 75.6% of mothers with children between 16 and 36 months.

C 1.2 There is an improvement in the percentage of children having a growth monitoring chart. According to the baseline survey, while only 25.9% of children less than 24 months old had a growth monitoring chart, the midterm evaluation survey indicates that 38.8% of children between 0 and 36 months now have one.

C 1.3 At the time of the midterm evaluation, the central pharmacy in Maroua had growth monitoring cards in stock which are distributed to health centers on a quarterly basis,

Weaknesses:

C 1.4 While 67% of mothers interviewed during the baseline survey knew that it is necessary to introduce foods other than maternal milk to their children between the ages of 4 and 6 months, only 41.8% of mothers interviewed during the mid-term evaluation said that they actually do this.

C 1.5 There is no apparent overall improvement in children's diets since the baseline survey. The table below shows the percentage of mothers who said they give their children the specified foods.

Percentage of Mothers who said their Children ate Nutritious Foods
I994 Baseline survey and 1995 Midterm survey results
Child Survival Project LX-Cameroon

FOODS EATEN BY CHILDREN BETWEEN 0-36 MONTHS OF AGE	BASELINE RESULTS	MIDTERM RESULTS
Cereal gruels	69%	61.2%
Gruels enriched with peanut butter or oil	--	29.6%
Gruels enriched with other oils or fats	10.9%	12.2%
Meat or fish	56%	27.6%
Eggs	33.9%	3.06%
Green vegetables	46%	54.1%
Fruits	33%	9.2%

An important difference should be noted in the phrasing of the question concerning children's diet, which could explain large differences in the responses, In the baseline survey, the question was asked as follows: *"Are you giving your child [name of food)?"* In the midterm survey, the question was asked as follows: *"What foods didyour child eat yesterday?"*.

Since the baseline survey did not specify a time period, it is likely that mothers' responses would have suggested higher frequencies of feeding nutritious foods than was actually the usual case. Mothers could have interpreted the question to mean *"Have* you *ever given your child (name* of *food)"* and could have replied "yes", even if their child ate the food only once in the last month. On the other hand, the midterm question specifies a limited time frame and it is likely that mothers' responses would have suggested lower frequencies of feeding nutritious foods than what is usual. While children may not have eaten expensive foods such as meat, fish or eggs the day before the survey, they may still have eaten them several times within the period of a week. This could explain in part the lower frequencies for these foods.

Nevertheless, the nutritional ideal is for children to eat protein sources, fats and oils, green vegetables and fruits on a daily basis.

C 1.4 The vast majority of mothers surveyed (97.2%) continue to give water to their children to drink prior to the age of six months. The project has thus not yet made an impact on this practice since the time the baseline survey was conducted.

C 1.5 Only 20.5% of mothers interviewed during the mid-term evaluation survey correctly identified the area on the growth monitoring chart indicating good nutritional status ("the good road to health").

C 1.6 The project sets the objective to weigh 22,036 children (48%) between the ages of 0 and 36 months at least once every three months. According to project documents, 7,406 children (24.6%) in this age group are currently weighed with this frequency.

C 2. **Training** and Education in Nutrition and Growth Monitoring

Strengths:

C 2.1 9,471 mothers have received education concerning breast feeding, weaning and nutrition.

C 2.2 Some health center personnel and health committees have received training about exclusive breast feeding, weaning and nutrition.

Weaknesses:

C 2.1 Although the project strategy called for the input of training at least sixty-six traditional birth attendants (TBAs) in nutrition, no efforts to date have been made to train TBAs or integrate them into the nutrition education component.

C 2.2 Interviews reveal that health center personnel and health committees feel that they need more training and audio-visual supports on the subject of nutrition.

C 3. Equipment, Supplies and **Logistical** Support for Nutrition and Growth Monitoring Activities

Strengths:

C 3.1 Observations and the review of project documents confirm that although the project had targeted the start-up of nutrition rehabilitation units, none exist. Project staff have chosen not to move ahead with separate units but will promote the referral of severely malnourished children for hospitalization. In this way, nutrition rehabilitation will be integrated into curative care services and facilities. Nevertheless, as indicated elsewhere in this report, the referral system is currently nearly non-existent.

Weaknesses:

C 3.2 The project had a stock-out of growth monitoring cards for nearly one year. Although it had budgeted for the production of these cards and funds were available, the project did not respond to the shortage. This could partially explain why less than half (38.8%) of children 0 to 36 months of age have growth monitoring cards.

C.4 Recommendations for the Nutrition Component

Save The Children and the Ministry of Public Health should:

C 4.1 Integrate traditional birth attendants into the nutrition component of the project strategy as described in the Detailed Implementation Plan (DIP).

C 4.2 Organize training and/or refresher courses for health personnel, health committees, women's groups *and traditional birth* attendants to help mothers interpret growth monitoring charts.

C 4.3 Provide a variety of audio-visual aids for health educators (health personnel and community volunteers) to facilitate educational lessons. Audio-visual aids should include:

* audio-taped stories, songs or theater skits; and
* illustrations painted on large cloth.

C 4.4 Initiate community meetings to raise awareness on the roles of community volunteers and the importance of community support in providing equipment to facilitate the volunteers' demonstrations of nutritional weaning foods. Such equipment would include ladels, spoons, cooking pots, wood for cooking fire, etc.

C 5.5 Organize an intensive information, education and communication (IEC) campaign targeting men in the communities to reinforce their perceived roles and responsabilities as as "heads of households". The IEC campaign should pass messages specifically tailored for husbands and fathers on purchasing or otherwise providing nutritious foods for mothers and young children in their households.

D. VITAMIN A

Summary: While there **is evidence that lessons on vitamin A deficiency can be well-**conducted at the level of Health Centers, this education has not had an impact on mothers' knowledge. The project has trained 12 health committees and 22 women's groups on the subject of Vitamin A, yet these groups have not demonstrated a tangible impact in passing on the information they have received to their communities. 55.4% of mothers surveyed did not know which foods can help prevent night blindness. Of women who said they have heard about night blindness, only 17.9% said they had received this information from health center personnel, 10.7% said they had received this information from health committees, and 1.8% said they had received it from women's groups.

Strengths:

Dl. Training and Education in Vitamin A -Deficiency Prevention

D 1.1 The evaluation team was able to observe two educational sessions, one on healthy weaning practices and the other on vitamin A-rich foods. The sessions were well-conducted by the health center personnel.

D 1.2 According to project documents, twenty-two (22) women's groups and 12 health and management committees have received training on the subject of the benefits and food sources of vitamin A.

Weaknesses:

D 1.3 The evaluators noted insuffkiencies in the supply of audio-visual educational materials available for use by the health center personnel, health committees and women's groups.

D 2. Community Knowledge and Attitudes about Vitamin A

D 2.1 Health center personnel, health committee members and women's groups have not yet demonstrated significant achievements at the community level on education about night blindness. Among the 57.1% of women who said they had heard about this illness:

- only 17.9% said they had received this information from health center personnel;
- only 10.7% said they had received this information from health committees;
- and only 1.8% said they had received it from women's groups

The majority of the women (76.8%) who had already heard about night blindness said that they had heard about the illness from other sources, primarily their children's' grandparents

D 2.2 Although fruits, particularly guavas, were available at the time of the mid-term evaluation:

- only 20% of mothers of children between the ages of 6 and 9 months;
- only 9.5% of mothers of children between the ages of 10 and 15 months;
- and only 9.8% of mothers of children between the ages of 16 and 36 months said that their children had eaten fruits the day before the survey.

D 2.3 Well over half (55.4%) of mothers said that they do not know which foods can help prevent night blindness.

D3. Equipment, Supplies and Logistical **Support** in Vitamin A-related Activities

Strengths:

D 3 1 Vitamin A capsules have recently become available at the district level t the level of the central pharmacy. Plans are underway to distributed them to the Health Centers soon,

Weaknesses:

D 3.2 Vitamin A capsules have been unavailable in the health centers up to the time of the midterm evaluation.

D4. Recommendations for the Vitamin A Component

Save The Children and the Ministry of Public Health should:

D 4.1 Organize an information, education and communication (IEC) campaign in the communities to reinforce the awareness-raising activities of the health committees and women's groups. The LEC campaign should use a variety of media (such as songs, theater plays, tee-shirts, audio-taped stories or fables, traditional Cameroonian media, informational radio spots) to promote the practice of eating fruits and others foods rich in vitamin A.

.3. MANAGEMENT OF PROJECT RESOURCES

3 A. Personnel

Save The Children-Cameroon employs twenty-eight full-time salaried personnel, most of whom work for the child survival project. Of these, only one is an expatriate. The breakdown of Save The Children employees in the project is as follows:

Yaounde

1 Administrative Assistant

Maroua (Save The Children-Cameroon Headquarters):

1 Country Representative
1 CS Project Support Officer
1 Accountant
1 Secretary
1 AIDS Project Coordinator
1 AIDS Project Assistant
1 Driver
10 Guards

Mayo **Danay:**

1 CS Project Coordinator
1 CS Project Assistant (Ministry of Agriculture and Community Development employee)
1 Secretary
1 Driver
3 Guards

Mayo Kani:

1 CS Project Coordinator
1 CS Project Assistant (Ministry of Agriculture and Community Development employee)
1 Secretary
1 Driver

Strengths:

A *3.1 Recruitment:* The project personnel is recruited following recruitment tests and interviews in concordance with the Cameroon Work Code.

A *3.2 Job Descriptions:* All Save The Children personnel have written job descriptions which describe their main role and responsibilities.
A 3.3 *Staff* In general, the project staff are hard working, motivated and competent in their roles and responsibilities.

A 3.4 The number and level of competence of the health center personnel is generally adequate.

A *3.5 New Hires:* The former Project Coordinator was replaced by Dr. Mathias Astatito, whose training and skills have been a beneficial addition to the project.

A *3.6 Work conditions:* Employees of Save The Children appreciate that they did not undergo salary reductions, Other private institutions have cut salaries at the request of the government to conform more to government pay levels. In general, Save The Children personnel feel that their work conditions, including resources made available to them, are satisfactory. Government personnel sometimes complained of low salaries, few opportunities for promotion, few incentives for good work, and limited means of transportation for work activities.

A 3.7 Save The Children adds 30% to the salaries of government employees seconded to the project as project assistants in the two divisions.

A 3.8 Save The Children project personnel receive on-the-job training and occasionally study visits outside of the country.

Weaknesses:

A *3.9 Changes in personnel:* Dr. Luke Nkinsi, Project Director, was fired in June, 1995. Dr. Mvongo Mbana Flauribert, former Project Coordinator for Mayo Danay was requested to leave the project by Save The Children. These departures, and events leading to them, caused serious delays in the implementation of project activities.

A *3.10 Job Descriptions:* Although Save The Children employees have written job descriptions, they do not clarify their roles with government personnel working in the project. Similarly, government personnel do not have clear descriptions of their roles with Save The Children employees. This lack of clarity has reduced efficiency in working relationships and collaboration between the non government organization (NG0) and the government.

A 3.11 Current project staff do not have the background or skills required for the position of Child Survival Project Director. Lack of experience among the project staff in training methods utilizing participatory adult learning methods poses a major constraint in implementing many of the information, education and communication activities in the project strategy.

A 3.12 Although they are generally hardworking, there are few examples of creativity or special initiatives taken by employees of both Save The Children and the government. Some government personnel attribute this to lack of incentives.

A 3.13 The Project Coordinator states that the number of personnel at Kaele is insufficient and requests another assistant.

A 3.14 Save The Children staff and government partners involved in planning and decision-making do not know the project budget. Project coordinators submit monthly activities' plans and spending on a monthly basis to the Country Representative for approval. The overall project budget is exclusively managed by the Country Representative and the accountant.

A 4. Recommendations for Management of Personnel and Human Resources

A 4.1 Save The Children and the Ministries of Health, Agriculture and Community Development, and Women's and Social Affairs should write clear job descriptions which identify the roles and responsibilities of each partner agency and each employee. The job descriptions should highlight and describe collaboration between the different players in planning, implementation, supervision and follow-up of activities.

A 4.2 Save The Children and the Ministry of Public Health should immediately recruit a Project Director to accelerate the implementation of activities and to provide supervision and support for the Project Coordinators. Given the urgency of the matter, the Project

Director should have a reputation for being dynamic and hard working, and should already be familiar with the public health care personnel, policies and infrastructure in Cameroon.

A 4.3 Although the project targets women and children, project decision-makers at national, provincial, district and village levels are all men. In light of this observation, Save The Children and the Ministry of Public Health should take advantage of the opportunity to add women to decision-making levels in the project by actively recruiting women candidates for the post of Project Director.

A 4.5 Save The Children and the Ministry of Public Health should integrate traditional birth attendants into the project activities, particularly prenatal consultations and maternal health care services.

B. Supervision of Personnel

Strengths:

B 1. Supervisions of health centers are scheduled and are conducted in teams composed of district-level representatives of the Ministry of Public Health and Save The Children.

B 2. Supervision checklists, developed by the Ministry of Public Health, address the activities of four main components of the project.

B 3. Health center personnel occasionally supervise health Committees and organized women's groups.

Weaknesses:

B 4. Although the Ministry of Public Health and Save The Children representatives do collaborate in supervising the health centers, these supervisions are not regular.

B 5. There is no formal nor regular system for supervising or providing feedback on the activities of the health committees in their communities.

B 6. The goals and meaning of supervision of personnel is not well understood by health center head nurses, who interpret supervision to mean "policing". Several of the head nurses interviewed gave "trust" as a reason why they do not supervise their personnel and the health committees more often:

> *"I have to trust them (the health center personnel). If I supervised them, they wouldn't appreciate it.. . they wouldn't be happy with me."*

B. 6 Recommendations for Supervision of Personnel

B 6.1 Save The Children and the Ministry of Public Health should meet to fix and adhere to a schedule of regular supervisions of the health areas. Supervisions should include observations of activities at the community level as well as at the level of the health centers.

B 6.2 Save The Children, the Ministry of Public Health, the Ministry of Agriculture and Community Development, and the Ministry of Women's and Social Affairs should meet to fix and adhere to a schedule of regular supervisions of health committees and women's groups during their IEC and community mobilization activities.

B 6.3 Save The Children and the Ministry of Public Health should strengthen communications between the districts and the project coordinators' offices.

C. Equipment, Supplies and Logistical Support

Summary: All of the six health centers visited had adequate supplies and materials to carry out all project activities as described in the Detailed Implementation **Plan** (DIP) with the exception of the immunization cold chain. Only one of the six centers had functioning refrigerators to store vaccines.

C 1. General Equipment and Supplies

Strengths:

C 1.1 All of the health centers visited had the following tools for the management of stocks and finances:

* Inventory sheet for essential drugs;
* Accounting books;
* A safe to keep money.
* Calculators.

It should be noted that the health centers do not keep inventory sheets for vaccines. These are kept at the district level.

C 1.2 The Save The Children Offices in Mayo Danay and Mayo Kani each have one vehicle and 1 motorcycle to facilitate transportation.

C 1.3 All of the six health centers visited have motorcycles for transportation. One motorcycle (at the Tchitibali health center) was not operational at the time of the midterm evaluation.

Weaknesses:

C 1.4 According to the September 1995 project pipeline report, the project has only spent 3.1% of its budget for equipment and supplies.

C 1.5 A confusion over the utilization of equipment and supplies exists in Doukoula, where the health center shares the same building with the hospital. In many instances, although equipment and supplies are physically accessible to the health center, because they have been officially designated for the hospital, health center personnel do not perceive that they have access to it.

c 2. Equipment and Supplies for Immunizations

Strengths :

C 2.1 The project has helped organize a regular schedule for immunization sessions in the health centers and in the villages developed by the personnel in collaboration with the health and management committees.

C 2.2 The project has financed the transport of five motorcycles belonging to the Ministry of Public Health from Yaounde to Maroua.

C 2.3 The central pharmacy in Maroua (CAPP) assures a continuous supply of disposable needles and syringes.

C 2.4 Save The Children has identified funds and will soon be assuring the repair of all refrigerators in the project area which are out of order.

C 2.5 The central pharmacy (CAPP) is establishing a system in which it will keep a stock of refrigerator and motorcycle spare parts to facilitate timely repairs.

C 2.6 Vaccination equipment was available in all of the health centers visited, including cold dogs (ice packs), sterilizing kits, single-use as well as sterilizable needles and syrmges.

Weaknesses:

C 2.7 An extremely important weakness revealed during observations conducted by the evaluation teams is that four of the six health centers randomly selected for visits did not have a functioning cold chain because the refrigerators were out of order.

C 3. **Equipment** and Supplies for Diarrhea1 Disease Control

Strengths:

C 3.1 All of the six health centers visited had supplies of ORS packets, and other material for demonstrations for the preparation of ORT solutions, such as one-liter measuring goblets, pots, coffee spoons, soap and a bucket. Most of the materials are in good condition.

c 4. Equipment and Supplies for Nutrition-Related Activities

Strengths:

C 4. I All of the six health centers visited had materials for nutrition-related activities, including weighing scales for children and weighing scales for adults. Materials for nutritional demonstrations were also available and in good condition at all of the health centers, including pots, spoons, ladles, plates, buckets, kerosene burners.

c 5. Equipment and **Supplies** for Vitamin A-Deficiencv Prevention

Strengths:

C 5.1 Vitamin A capsules are available at the district level and will be soon distributed to the Health Centers.

Weaknesses:

C 5.2 Interviews revealed that vitamin A capsules foreseen in the strategy were not yet available in the Health Centers at the time of the mid-term evaluation.

C 6. Recommendations for Equipment and Supplies:

Save The Children should:

C 6.1 Inform Project Coordinators and partner agencies of the project budget to facilitate collaboration in decision-making and rational use of funds.

C 6.2 Accelerate the provision of remaining equipment and supplies for the twenty-two health centers supported by the project.

C 6.3 Continue with its plans to repair, or where possible replace, all nonfunctioning refrigerators.

4. MANAGEMENT AND USE OF DATA

Summary: No data collection tool for the health information system exists at the community level. At the level of health centers, and in **offices** of the Ministry of Public Health and Save The Children (SC) in the districts and provincial capitol, systematic data collection is in place for what are essentially two separate health information systems. There is little or no exchange of data generated by these systems between the MOH and SC. Data is compiled manually by the Ministry of Public Health at the level of the districts, but none of the government offkes have calculators. The Save The Children office in Mayo Danay has a computer which analyzes project data collected for SC reporting.

A. Data Collection Tools

At the household level:

Children's health cards were found in households in the action areas of four of the six health centers visited by the midterm evaluators.

At the community level:

There are no official forms for collecting demographic data. Births are verbally declared to the head nurses of the health centers by the health committees during their quarterly meetings.

No system is in place for mothers and children who drop out from the project's child survival activities.

At the health center level:

Monthly reports compiling data from preventive and curative health care activities in the health area covered by the health center are prepared by the head nurses and submitted to the Ministry of Public Health (MOH) at the district and provincial offices.

One-page summary sheets of monthly project activities, particularly those concerning information, education and communication, are prepared by head nurses in the health centers of Mayo Danay division and submitted to the Project coordinator based in Doukoula.

At the district level (Ministry of Public Health):

None of the MOH offices at the district level have calculators. Nevertheless, the rest of the health information system tools are available. These include monthly reports, supervision checklists, supervision report forms and data analysis report forms.

The MOH does not receive the project activities summary sheet produced by Save The Children and compiled by the health centers.

At the district level (Save The Children):

The Save The Children offices in Mayo Danay and Mayo Kani have all of the standard health information tools, including supervision checklists, supervision report forms and data analysis report forms. These offices do not, however, receive the monthly activities reports compiled by the health centers and submitted to the MOH

The Save The Children office in Doukoula is equipped with a computer and a data analysis program which is used to compile and analyze the data collected from the project activity summary sheets for both division.

At the provincial level (the MOH): The office of the provincial delegate for the Ministry of Public Health received a computer and printer through Save The Children for data analysis.

B. Data Analysis and Decision-Making

Analysis and Use *of* Data

The Ministry of Public Health (MOH) and Save The Children (SC) currently analyze and use data independently from each other. The MOH and SC have little or no exchange of information concerning the data they retrieve.

Decision-Making Based on Data Analysis

The evaluators observed that the health center head nurse and the members of the health committees occasionally make decisions for certain local problems revealed by the health information system.

At the level of the district and the provinces, there is little or no joint decision-making between the MOH and Save The Children based on health information data.

Within Save The Children, the decision-making process usually entails the Project Coordinators discussing health information system data and proposing actions with the Country Representative.

C. Health Information Indicators

Health information indicators correspond to the main objectives for the vaccination, nutrition, diarrhea1 disease control and vitamin A components. Indicators that were identified in the project strategy to monitor progress, but are not currently used in the project are:

1. # & % of children 12-23 mos.
2. # & % of women of CBA immunized against tetanus by number of doses received
3. # & % of children O-36 mos. moderately malnourished
4. # & % of children O-36 mos. severely malnourished
5. # of ORS packets sold per month
6. # & % of cases of diarrhea during the last three weeks that were treated by ORT
7. # & % of cases of night blindness, xerophthalmia, measles, chronic diarrhea, and **acute** respiratory infection that treatment included vitamin A capsules.
8. # & % of women of CBA who know the advantages of immunization.

D. Recommendations for Management of Health Information Data

D 1. The Ministry of Public Health (MOH), the Ministry of Women's and Social Affairs, the Ministry of Agriculture and Community Development and Save The Children (SC) should collaborate in data analysis and increase the exchange of information between their agencies.

D 2. The MOH and SC should work to standardize a single health information system that is utilized by both partners.

D 3. MOH, MWSA, MACD and SC should send copies of their data analysis results and feedback provided to health centers to each other's offices at the provincial and district levels.

5. COLLABORATION WITH OTHER AGENCIES/COUNTERPART RELATIONSHIPS

5 A. Government Agencies

Strengths:

5A. 1 Collaboration exists between the Ministry of Public Health (MOH) and Save The Children (SC), who conduct supervisions of health centers together.

5A. 2 Personnel from the MOH, the Ministry of Agriculture and Community Development (MACD) and the Ministry of Women's and Social Affairs (MWSA) participate in training seminars organized by SC.

5A. 3 MOH employees are seconded to the project in the Mayo Kani Project Coordinator posts and in the Child Survival Project Manager position and employees from the MACD are seconded as project assistants.

5A.4 At the field-level, through good, yet rather informal working relationships, SC, MACD and MWSA personnel collaborate to train health committees and work with women's groups.

Weaknesses:

5A.5 Aside from the examples cited above, collaboration in the planning, budgeting and implementation of activities, in data collection and analysis, and in decision-making is not well-organized between the Ministry of Public Health, the Ministry of Agriculture and Community Development, the Ministry Women's and Social Affairs and Save The Children.

5 A.6 No regular, formalized forum exists for dialogue and exchange of information between these four partner agencies.

5 A.7 There are no written documents detailing collaboration between the four agencies

5 A.8 While Save The Children staff are very familiar with the project's Detailed Implementation Plan (DIP), with the exception of the MOH-seconded Project Coordinator in Mayo Kani, most of the government staff in important project-related positions are not familiar with the document and do not know the objectives and strategies of the project.

5 A.9 The project has not yet initiated an active role for the Ministry of Women's and Social Affairs in planning and implementing strategies involving organized women's groups and gender issues.

5 A. 10 The partner government agencies are not informed of the project budget and do not participate in decision-making regarding use of funds for project activities.

B. PVO/NGOS

Strengths:

B. 1 The health areas are well delineated and designated in a rational way between the different agencies working in community health care.

Weaknesses:

B.2 The project does not benefit from the experiences of the religious institutions or groups working in community health who have demonstrated particular achievements in organization of activities and quality of care.

C. Recommendations for Improving Collaboration and Networking between Partner Agencies

C. 1 The Ministries of Public Health (MOH), Women's and Social Affairs (MWSA), Agriculture and Community Development (MACD) and Save The Children should organize a meeting between these four partners at the national, provincial and district levels to review and discuss the findings and recommendations of this report.

C.2 These four partner agencies should also organize meetings at all levels, including the level of the community, to:

* review and if appropriate modify the project strategy, goals and objectives in simple, straightforward language that all of the participants at the meetings can understand;

* write job descriptions which clarify roles and responsibilities of each partner (agencies, committees and key individual posts) that emphasize collaboration between the different partners.

c.3 Save The Children and the Ministry of Public Health should request and utilize the experiences of the religious groups in community health activities and quality of care.

C. 4 The Ministry of Public Health should assure that coordination meetings and information exchange are held at least once each quarter at the district and provincial levels between the different partners involved in the project.

6. COMMUNITY PARTICIPATION

A. Health and Management Committees

The government's reorientation strategy for primary health care calls for the creation of committees as structures for dialogue and joint decision-making between health care officials and communities. The committees are formed on three levels:

1. *Village* level: Village Health Committees (VHCs) are supposed to be elected democratically by their communities. Their main responsibilities are currently to inform, educate and mobilize mothers to adopt specific health behaviors. The VHF members are supposed to meet on an as-needed basis to make decisions and initiate actions to improve community health in general (including child survival).

2. Health area level: Two members from each VHF and supposed to be democratically elected to sit on a larger health committee which represents all of the villages in a health area. The health committee members are supposed to meet on a quarterly basis with the health center head nurse to represent the interests of the beneficiaries and to facilitate information exchange between their communities and the government health service.

3. Health center level: A sub-group of the large health committee is also elected to sit on the management committee. This committee is supposed to meet on a monthly basis with the health center head nurse to oversee the general management of the health center.

Strengths:

1.1 Focus group discussions held with members of health committees confirmed that members are well aware of the health problems in their communities, particularly those related to child survival such as malaria, measles, diarrhea, whooping cough, infant mortality and malnutrition.

1.2 Health committees also understand their role:

> *"We raise awareness of the population on health problems, facilitate exchange of information between the health center and the population, co-manage the center.*

> *"Our duties are to meet twice a week to talk about nutrition, exclusive breast feeding, vaccinations, prenatal consultations, building community health posts."*

1.3 Most functioning health committees meet on a quarterly basis with health center head nurses. Most functioning management committees meet on a monthly basis with the head nurses. Members of both committees often expressed their satisfaction with the opportunity to regularly discuss their community health issues with health center personnel.

1.4 Management committees participate in joint decision-making and co-managing of some health center activities, particularly those linked to the pharmacy, with the health center head nurse.

1.5 Although some health committee members brought up problems they have with credibility, most expressed the belief that their communities understand and appreciate their role and some mothers follow their advice:

> *"It's difficult work because awareness-raising is not easy especially when the population doubts the credibility of the health committee and management committee members."*

> *"Some mothers already practice exclusive breast feeding for three months, the women give oral rehydration solution."*

1.6 Focus group discussions confirmed that beneficiaries not only have some understanding of the health committees' role, but believe they should be provided with incentives:

> *"The health committee advises us about feeding children enriched gruels, liver and meat, and weighing pregnant women and children."*

> *"The members inform us about nutrition, vaccination, constructing latrines, prenatal care, exclusive breast feeding, enriched gruels."*

> *"'It's difficult to raise awareness because the population has difficulty understanding. "*

> *"The members of the health committee pass more time doing awareness-raising than doing their own work in the fields."*

> *"It's up to the people in the villages to pay them."*

> *"We could thank them with a little "thirty-three" (popular brand of beer) because the work is hard."*

> *"The community shouldpay them."*

> *"They must be given incentives by the community or by the government."*

Weaknesses:

1.7 Interviews, focus group discussions and review of management committee reports revealed that neither the management committee members nor the health center nurses fully understand the role of the health center management committee. Dialogue and decision-making are typically limited to counting the revenues generated by the health center and preparing the next order for medicines and supplies from the central pharmacy. In monthly meetings that generally last less than an hour, the members rarely discuss how to improve the quality of services provided in the health centers.

"(Management committees) hold meetings to get information about the price of medicines, do the monthly treasury report, estimate the financial needs andplan expenses. The meetings are monthly."

1.8 Financial incentives are a constant subject of debate in both the health committees and the management committees. Interviews revealed that in at least one of the health centers visited by the evaluators, management committee members divide part of the revenues from the health centers each month for their personal earnings.

1.9 Although one health committee at the district-level of Kaele was recently installed, none of the three health areas in the Mayo Kani district visited by the midterm evaluators had functioning health committees or functioning management committees.

B. Women's Groups

Summary: Although nearly 40 women's groups in the two departments have received some training and have demonstrated their interest in promoting child survival activities, these groups have not been integrated into the health centers' community education and outreach programs.

A review of project documents reveals that there are approximately 40 women's groups who have already received some training in health topics. Training was conducted by government community development field agents who collaborate with the project.

Two organized women's groups participated in focus group discussions for the mid-term evaluation in the villages. The guide used for the discussions addressed women's groups' knowledge, attitudes and practices on the following themes:

1. The role, responsibilities and tasks of women's groups;
2. Overall status of community health;
3 Immunization;
4. Diarrhea prevention and treatment;
5. Prevention of malnutrition and Vitamin A deficiency;
6. Quality of health care services;
7. Financial management of the health center.

The complete guide used for discussions with the women's groups is included in Annex E.

Women's groups have a number of activities, many of which concern their primary objective: income-generation. Among the group activities cited by the women are agriculture, pig-raising, a group savings and loan account ("tontine") and small business affairs. In addition, thanks to training provided by community development field agents ("animatrices"), women's groups are also involved in health promotion activities in their communities. The members recognize the importance of vaccination and work to raise awareness of other women. Women's groups also help to organize the vaccination sessions held in their villages:

"We help mothers with advice and traditional medicines."

"If there is no other solution, we orient them towards the hospital."

"We tell other women about the vaccination schedule and urge the pregnant women and children to go to the vaccinations. "

"We meet every two weeks to discuss problems of pregnant women and children. "

"Once a month, a member he&prepare the vaccination site and hold the children (who may cry and struggle while they are being vaccinated)."

Women's groups demonstrated a strong sense of identity, unity and motivation to improve their lives and their communities. They often expressed the need for advice, guidance and skills development provided by outside resource people to support their efforts.

"(The role of the group) is to help our village progress."

"We find that the group's work is not difficult, all we must do is get along together. "

Community opinion of women's groups varies but is generally positive. Members of women's groups expressed the following perceptions of community opinion:

"Some people understand us. Others do not."

"They (the community) are happy with us."

"They say we're crazy that we are wasting our time."

While male beneficiaries who participated in the focus group discussions generally had no comment about women's groups, women in the communities felt that women's groups work hard:

"The job of a women's group is a big job. Difficult."

"They pass the whole day at the health center giving out medicines and sweeping the health center. It 's difficult."

"Women 's groups give advice on oral rehydration, on vaccinations, on exclusive breast feeding up to six months."

"All the time in meetings. "

"The community doesn 't thank them. "

C. Gender Issues in Community Participation in Child Survival Activities

Strengths:

C 1. Communities have established clearly defined gender roles for parents in promoting child survival activities. Fathers are particularly responsible for encouraging mothers to bring their children to vaccination sessions and for providing financial assistance for the purchase of needles, syringes, growth monitoring cards, and nutritious foods:

> *'Men think that the father should encourage the mother to vaccinate the child and that it is the father who should buy the milk, eggs, peanuts, oil, fruits and the mother should give her child nothing but breast milk up until six months of age."*
>
> *"It's men who have the money for syringes and the mother is supposed to bring the child to the vaccination session."*
>
> *"Fathers worry more about providing food than about educating children."*
>
> *"Women participate more in the nutrition education demonstrations and sometimes the fathers do because of their power in decision-making."*

C 2. The health committees, composed mostly of men, provide a structure for men in the community to become informed and actively involved in child survival activities.

C 3. Focus Group Discussions showed that while Health Committees and Management Committees are, without exception, groups initiated by "outsiders", women's groups are created in a variety of ways: sometimes by the initiative of an "outsider" and sometimes by the initiative of the women themselves. In any case, organized women's groups have a primary goal of helping each other:

> *"It was an animatrice (a female community development agent) who came to bring us together."*
>
> *"(Our group began) on our own initiative."*
>
> *"We meet to get along together and to find someone to help us."*
>
> *"(We meet to) help each other... financially or in our work."*

Weaknesses:

C 4. Although over 95% of health committee members are male, most of the health committee members, as well as most of the health personnel at all levels of decision-making, maintain that the process by which they were elected was democratic.

C 5. Training, follow-up and support for women's groups and that for the predominately male health committees are evolving in parallel programs.

C 6. Interviews with health center directors revealed that, although they meet regularly with the predominantly male Management Committees and Health Committees, they have

no contact with women's groups and are unaware of their activities. The health center directors are also unaware that the project strategy called for the integration of the women's groups into child survival activities.

C 7. Focus Group Discussions with members of women's groups and the health and management committees showed that there women's groups have little or no collaboration with the other, predominately male groups:

> *"There is no collaboration between the health committee and our group."*
>
> *"We met with them once."*

C 8. Focus group discussions with adult beneficiaries indicated that men are more aware of the activities of the mostly male health and management committee activities and women are more aware of the organized women's groups' activities.

D. Recommendations for Improving Community Participation and Women's Empowerment

D 1. The project should design a strategy to provide incentives for organized women's groups, health and management committees and traditional birth attendants in their community health activities.

D 2 The following specific actions should be taken to implement the above recommendation:

- The Project Coordinators, Chief Medical Doctors for the districts, Health Center head nurses and educators *("animateurs")* of the Ministry of Agriculture and Development and the Ministry of Women's and Social Affairs should begin a direct dialogue with the communities to identify resources for these incentives.

- Save The Children, the Ministry of Public Health, the Ministry of Agriculture and Development and the Ministry of Women's and Social Affairs should begin a dialogue to discuss proposals from the communities and the district-level offices to design a realistic policy concerning incentives for health committees, management committees, women's groups and traditional birth attendants.

D 3. The Project Coordinators should initiate the integration of the training and follow-up support provided for health and management committees and organized women's groups. The Project Coordinators should at the same time initiate and support collaboration between these groups.

D 4. At district, provincial and national levels, project officials from Save The Children, the Ministry of Public Health, the Ministry of Agriculture and Community Development, and the Ministry of Women's and Social Affairs should organize coordination meetings in which they should clearly define the roles and responsibilities of each partner at each level

in the training, follow-up and support of communities and community volunteer groups in the project area.

D 5. The Project Coordinators, the Health Center head nurses and the community development educators *("animateurs")* should design and implement a strategy to increase the active participation of women in organized structures for discussion, decision-making and management for project resources and activities.

D 6. If no local examples of successful integration of women into active participation in child survival projects exist, Save The Children and the Ministry of Public Health should send the Project Coordinators to observe such examples in other countries (for example, Burkina Faso or Mali).

7. QUALITY OF CARE

Summary: The health centers have an adequate number of personnel providing curative care. In general, the accessibility of curative care services and the level of diagnosis and treatment are of good quality. Health centers have adequate supplies of essential drugs. Beneficiaries and the health and management committees have varying opinions about the affordability of these drugs and sometimes complain that the drugs have passed their expiration dates. The health centers lack some technical equipment and a formal, organized referral system.

A. Preventive Health Care

7A. 1 Immunizations of women and children, health education, prenatal consultations and maternal care services are provided on a daily basis in the health centers.

7A. 2 Health center personnel conduct outreach activities once a month in strategic health posts in certain villages. Outreach activities include prenatal consultations, immunizations of children from 0 to 36 months, growth monitoring and education on nutrition and exclusive breast feeding.

B. Curative Health Care and Referrals

Strengths:

7B. 1 The health centers have an adequate number of personnel providing curative care.

7B. 2 An essential drug procurement system exists and functions well through a central pharmacy in the regional capitol of Maroua and in health center pharmacies.

7B. 3 With the exception of vitamin A capsules, stock-outs of essential drugs at health center pharmacies do occur but are rare. The Maroua pharmacy restocks drugs and supplies on a quarterly basis.

7B. 4 Although some beneficiaries complain of the prices, the drugs are nevertheless purchased by the communities at a rhythm which permits cost-recovery. Drug sales and consultation fees for curative care provide revenues to cover the salary of the health center pharmacy employee, maintenance of materials, transport, office supplies, medical equipment and motorcycle repairs.

7B. 5 Beneficiaries are generally satisfied with the quality of curative care provided by the health centers. Many commented that they are usually treated courteously by the health center personnel.

7B. 6 Five of the six health centers visited fulfill the required conditions to permit a good diagnosis and treatment of illnesses.

Weaknesses:

7B. 7 Some health centers, although they have a laboratory and microscope, do not have a lab technician. Health and management committees, beneficiaries and health center personnel all expressed the need to have this level of competence in the health centers.

7B. 8 Health and management committees expressed concern over the quality and price of the essential drugs sold at the health center.

> *"Eke central pharmacy (CAPP) should avoid selling us expired drugs."*

> *"'It's necessary to really explain to the population the risks one runs in buying medicines (illegally imported) from Nigeria."*

7B. 9 Cost-recovery from drug sales and consultation fees are insuffkient to cover building, renovating or enlarging the health centers.

7B. 10 Vitamin A capsules were not available in the health centers at the time of the midterm evaluation.

7B. 11 The community committees and the beneficiaries frequently expressed their desire to have easier access to basic drugs, particularly anti-malarial drugs and aspirin. Some health center head nurses explained that the government policy to close community health posts which provided basic drugs and first-aid services has deeply disappointed communities and diminished their interest in collaborating with the government health services.

> *"The population does not have enough financial means to seek curative care in the health centers."*

> *"Pregnant women prefer to go to private health centers that are less expensive."*

> *"The government should allow the village health posts to reopen so that we can (easily obtain) drugs."*

7B. 12 Barriers to access identified by health committees and beneficiaries include:

> *"The family's poverty and the costs of treatments."*

> *"The distance between the health centers and some of the remote villages."*

> *"The condition of the roads."*

"Some of the health personnel refuse to intervene in emergencies." (Case of one health area.)

7B. 13 Although the midterm evaluators did not have a standard list of health center equipment, they did note that of the six health centers visited, only one (Guidiguis) had an exam table for prenatal consultations and general physical exams.

7B. 14 There were extremely poor conditions of cleanliness observed in one of the delivery rooms visited (Doukoula). The delivery room also lacked a complete delivery kit.

7B. 15 Records of patient referrals were found in only two of the six health centers visited (Kalfou and Guidiguis). There were absolutely no records of counter referrals in the health centers.

7B. 16 The geographic and economic accessibility of reference centers are generally good in the dry season but difficult in the rainy season.

7B. 17 Supervisions of curative and preventive care services occur, but are few and infrequent. No records of outcomes of this supervision, including feedback, exist in the project offices of Save The Children.

C. Recommendations for Improving Quality of Services

C 1. The Ministry of Public Health should assure that all seven health districts improve and formalize the referral and counter-referral system.

C 2. The Ministry of Public Health and Save The Children should reinforce the technical equipment in hospitals in the seven districts and the twenty-two health centers to improve the quality of health care service delivery.

8. INFORMATION, EDUCATION AND COMMUNICATION

Summary: IEC activities held in the health centers and in the communities concentrate on maternal and child health. Activities are limited to the classic "health discussion" lesson. While health center personnel conduct these lessons well, it is evident that members of health committees and women's groups need more training to develop skills for leading group discussions and educational talks. Both in the health centers and in the communities, health IEC materials are of limited quantity and usually consist of either posters or illustrated flipcharts. More creative, culturally-appropriate health IEC materials and supports, such as audio tape-recorded songs and fables, and live or recorded theater plays do not exist in the project.

Strengths:

8.1 With the exception of Doukoula, all of the health centers visited by the midterm evaluators had a posted schedule of IEC activities.

8.2 IEC activities cover the four major components of the project: immunization, nutrition, diarrhea1 disease control and vitamin A.

Weaknesses:

8.3 While health committee members and health center personnel have mastered most of the project health messages, there is nonetheless some confusion or variation in some of the messages, particularly concerning exclusive breast feeding and diarrhea1 disease control.

8.4 Health committee members and health center personnel would like more information and training in the area of nutrition, which they perceive as the least well-developed subject.

8.5 There is no organized strategy for targeting and improving specific subjects in mothers' and fathers' knowledge, attitudes and practices. For example, although mothers' knowledge of the benefits of immunization has always been high, health center personnel and health committees continue to emphasize the benefits of immunization in their IEC activities. Yet while baseline and midterm evaluations show that mothers' knowledge of the ages at which children should receive immunizations or mothers' knowledge in interpreting growth monitoring charts is low, health center personnel and health committees have not seemed to reinforce this information.

A. Recommendations for Information, Education and Communication

A 1. Save The Children should utilize some of the project funds reserved for the production of culturally-appropriate IEC materials for each of the four components of the project. The materials should include audio tape-recorded fables and songs, and illustrations painted on large pieces of cloth. Health center personnel and members of health committees and women's groups should be provided with these materials and trained to use them correctly.

A 2. Save The Children and the Ministry of Public Health should utilize some of the project funds reserved for equipment and supplies to provide the twenty-two health centers in the project area with IEC material for each of the four components of the project.

A 3. Save The Children and the Ministry of Public Health should review knowledge, attitudes and practices levels and standardize all of the project's main health messages accordingly. These same agencies should then issue clear instructions to the project personnel and members of health committees and women's groups to assure correct transmission of the messages.

9. Training

Strengths:

9.1 Health center head nurses have participated in trainings organized by the project in each of the four main components.

9.2 Training for health committee members is scheduled and covers the four main project components. Training sessions are held for the health committees every two weeks at the health centers. Trainers for these sessions are the health center head nurses and the community development project assistants.

9.3 Members of organized women's groups also receive training in some of the project components, although the sessions do not appear to be scheduled on a regular basis and do not appear to be as comprehensive as those organized for the health committee members. Trainers for these sessions are usually personnel from the Ministries of Agriculture and Community Development and Women's and Social affairs. Health personnel rarely if ever participate as trainers in these sessions.

Weaknesses:

9.4 None of the project health personnel who are trainers for the health committees have actually received training as trainers of adults.

9.5 Training of health committees and of women's groups primarily uses the classical "classroom" approach rather than adult participatory learning methods.

9.6 Although trainers have didactic information and technical notes, no standardized training modules exist.

9.7 Although the primary role of members of health committees and organized women's groups is to inform, educate and communicate with their communities to increase their participation in child survival activities, these groups do not receive sufficient training to develop IEC skills and do not have IEC audio-visual supports,

9.8 The length of the training sessions for health committees is generally insufficient to assure the participants' mastery of knowledge, attitudes and skills. Training on a subject usually last no longer than two hours. In addition, the number of participants at the training sessions is usually between 20 and 40 people. This large number of participants decreases the effectiveness of the training.

A. Recommendations for Improving Training Activities

A 1. Save The Children and the Ministry of Public Health should program a training of trainers (TOT) for project personnel from the different partner agencies implicated in the education of health and management committees and women's groups. The TOT should concentrate on adult learning theory and participatory methods of training.

A 2. Save The Children should assure the identification or development of a standardized training module for each of the four components. The module should use training methods for adults with no or low literacy skills such as roles plays, simulations, fables, proverbs, and practical exercises.

A 3. Save The Children and the Ministry of Public Health should review and modify the current training strategy. To maximize effectiveness in the participants' mastery of new knowledge, attitudes and skills:

- the duration of training seminars should be increased from several hours to three to five days;

- Provided that the duration of the seminars can be increased, their frequency should be decreased (at most, every other month); and

- the number of participants in each session should not exceed fifteen people.

10. Technical Support

Strengths:

10.1 The project has received support from Save The Children headquarters in Connecticut and the sub-regional office during technical assistance visits.

10.2 Tulane University, the Centers for Disease Control, and the Martin Luther King/Charles Drew Medical Center are United States institutions who have provided technical assistance to the project for the baseline research and the development of the Detailed Implementation Plan (DIP).

10.3 The Ministry of Public Health (MOH) has provided technical assistance to the project at every major phase: baseline study, project design, and implementation of activities. The MOH and the Ministry of Agriculture and Community Development (MACD) have seconded personnel to work with the project. The MACD and the Ministry of Women's and Social Affairs have provided technical assistance in the training and follow-up of health committees and women's groups.

Weaknesses:

10.4 The project has not received enough technical assistance to assure the design and development of effective training strategies for the health committees and organized women's groups.

10.4 The project has also not received enough technical assistance to assure effective, gender-sensitive strategies promoting women's active participation in dialogue and decision-making in child survival activities.

A. Recommendations for Improving Support Headquarters and the Regional Office

A 1. Save The Children headquarters in Connecticut should provide more documentation for the project on the experiences of other child survival projects (training modules, IEC materials, community participation methods, women's empowerment initiatives). Where appropriate, the headquarters should assist in identifying other projects for study and exchange visits for the Cameroon project staff.

A 2. The Ministry of Public Health and Save The Children-Cameroon should more actively seek out technical assistance from the Ministries of Agriculture and Community Development and Women's and Social Affairs in these domains,

A 3. The Save The Children Country Representative should visit project activities in the two divisions more regularly (at least twice a year) to follow the development of the project, meet with project collaborators at the district-levels and to maintain a positive image of Save The Children through official, high-level "presence".

11. BUDGET MANAGEMENT

The most recent pipeline analysis (9/21/95 - annex F) shows that the overall project budget is underspent in most cost centers. The project has spent the following percentage of the total budget for the specified cost centers:

Direct Cost Centers	Percent of Total Budget Spent
A. Personnel	39.4%
B. Travel	53.7%
C. Consultants	0.0%
D. Procurement	3.1%
E. Other Direct Costs	80.2%
TOTAL DIRECT COSTS	42.0%

Due to a variety of constraints, particularly linked to turnover of key personnel, the project is running approximately eight months behind schedule. The evaluation team is concerned that a rational and efficient use of remaining funds may be jeopardized by an effort to accelerate spending for the year left in the life of the project.

A. Recommendation:

To help the project achieve its objectives with the remaining funds, the evaluators are therefore recommending that Save The Children and the Ministry of Public Health request a no-cost extension for eight months.